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: 141341	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/25/2016 3:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2016 Time: 3:25 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PANA COMMUNITY HOSPITAL (141341) for the cost reporting period beginning 01/01/2015 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 V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	107,342	-355,596	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	19,680	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		94,531		0	10.00
200.00	Total	0	127,022	-261,065	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 101 E. 9TH STREET	PO Box:			1.00
2.00	City: PANA	State: IL	Zip Code: 62557-1716	County: CHRISTIAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PANA COMMUNITY HOSPITAL	141341	99914	1	11/01/2004	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	PANA COMMUNITY HOSPITAL	14Z341	99914		04/06/2004	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	QUAD COUNTY HOME HEALTH AGENCY	147299	99914		01/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	PCH HOSPICE	141575	99914		08/31/1994				14.00
15.00	Hospital-Based Health Clinic - RHC	COMMUNITY MEDICAL CLINIC PANA	148508	99914		03/18/2010	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 12:30 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 12:30 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 12:30 pm

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	61,930	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 12:30 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141341	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/23/2016 12:30 pm

		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. I, 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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2016 12:30 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/30/2016	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.	Y			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	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/06/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2016 12:30 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2016 12:30 pm

		Part B Date			
		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)	04/06/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			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.		DIRECTOR, REIMBURSEMENT		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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2016 12:30 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	18,432.00	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)		22	8,030	18,432.00	0	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)		22	8,030	18,432.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		22				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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	633	9	768			1.00
2.00	HMO and other (see instructions)	65	16				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	334	0	352			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	3			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	967	9	1,123			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)	967	9	1,123	0.00	124.94	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,290	0	4,396	0.00	8.67	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,727	0	11,188	0.00	14.26	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	147.87	27.00
28.00	Observation Bed Days		0	146			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			2			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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	212	6	283	1.00
2.00	HMO and other (see instructions)			30	8		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	212	6	283	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						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: 141341 | Component CCN: 147299 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-4 | Date/Time Prepared: 5/23/2016 12:30 pm

Home Health Agency I | PPS

		1.00	
0.00	County	CHRISTIAN	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	156	14	42	212	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	199.00	18.00	57.00	274.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		2.28	0.00	2.28	5.00
6.00	Direct Nursing Service		3.39	0.00	3.39	6.00
7.00	Nursing Supervisor		1.15	0.00	1.15	7.00
8.00	Physical Therapy Service		1.61	0.00	1.61	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.05	0.00	0.05	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.19	0.00	0.19	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	735	33	46	7	821	21.00
22.00	Skilled Nursing Visit Charges	131,119	5,899	8,191	1,251	146,460	22.00
23.00	Physical Therapy Visits	1,327	1	24	19	1,371	23.00
24.00	Physical Therapy Visit Charges	236,986	179	4,243	3,396	244,804	24.00
25.00	Occupational Therapy Visits	71	0	0	13	84	25.00
26.00	Occupational Therapy Visit Charges	13,703	0	0	2,509	16,212	26.00
27.00	Speech Pathology Visits	7	0	1	0	8	27.00
28.00	Speech Pathology Visit Charges	1,351	0	193	0	1,544	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	6	0	0	0	6	31.00
32.00	Home Health Aide Visit Charges	647	0	0	0	647	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,146	34	71	39	2,290	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)	383,806	6,078	12,627	7,156	409,667	35.00
36.00	Total Number of Episodes (standard/non outlier)	164		25	3	192	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	9,083	0	753	99	9,935	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141341 Component CCN: 148508 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/23/2016 12:30 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	101 E. 9TH STREET, SUITE 105	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PANA	IL	62557	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	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

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:30	20:00	08:30	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		CHRISTIAN				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	20:00	08:30	20:00	08:30	20:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141341 Component CCN: 148508	Period: From 01/01/2015 To 12/31/2015	Worksheet S-8 Date/Time Prepared: 5/23/2016 12:30 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:30	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141341	Period: From 01/01/2015 To 12/31/2015	Worksheet S-10 Date/Time Prepared: 5/23/2016 12:30 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.382974	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,045,334	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	9,860,928	6.00
7.00	Medicaid cost (line 1 times line 6)	3,776,479	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)	1,731,145	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	20,532	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,731,145	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		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	11,139	56,764	67,903	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	4,266	21,739	26,005	21.00
22.00	Partial payment by patients approved for charity care	1,662	7,009	8,671	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,604	14,730	17,334	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,482,333	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	215,991	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,266,342	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	484,976	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	502,310	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,233,455	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		398,026	398,026	17,880	415,906	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		929,008	929,008	13,747	942,755	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,159,930	2,159,930	-6,647	2,153,283	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	148,603	148,603	5.01
5.02	00550	DATA PROCESSING	236,498	276,180	512,678	-107,981	404,697	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	366,541	278,346	644,887	-40,622	604,265	5.03
5.04	00590	OTHER ADMIN AND GENERAL	597,135	883,874	1,481,009	50,192	1,531,201	5.04
7.00	00700	OPERATION OF PLANT	177,204	343,027	520,231	683	520,914	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	68,288	68,288	8.00
9.00	00900	HOUSEKEEPING	169,051	92,802	261,853	-68,288	193,565	9.00
10.00	01000	DIETARY	179,830	180,228	360,058	-317,455	42,603	10.00
11.00	01100	CAFETERIA	0	0	0	114,338	114,338	11.00
13.00	01300	NURSING ADMINISTRATION	276,806	3,375	280,181	0	280,181	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,788	12,354	32,142	0	32,142	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144,906	71,991	216,897	0	216,897	16.00
17.00	01700	SOCIAL SERVICE	44,888	7,120	52,008	0	52,008	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	86,885	1,792	88,677	6,647	95,324	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	634,083	138,720	772,803	0	772,803	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	333,330	120,049	453,379	0	453,379	50.00
53.00	05300	ANESTHESIOLOGY	0	5,648	5,648	0	5,648	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	468,070	849,495	1,317,565	0	1,317,565	54.00
60.00	06000	LABORATORY	549,506	433,132	982,638	0	982,638	60.00
65.00	06500	RESPIRATORY THERAPY	353,077	121,177	474,254	0	474,254	65.00
66.00	06600	PHYSICAL THERAPY	432,252	43,504	475,756	0	475,756	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,717	9,717	0	9,717	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181,013	1,133,194	1,314,207	0	1,314,207	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,206,654	275,159	1,481,813	0	1,481,813	88.00
91.00	09100	EMERGENCY	801,045	1,477,139	2,278,184	0	2,278,184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	474,008	113,474	587,482	0	587,482	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	163,402	99,144	262,546	0	262,546	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,895,972	10,457,605	18,353,577	-120,615	18,232,962	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	431,878	72,959	504,837	-683	504,154	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	121,298	121,298	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	78,451	40,597	119,048	0	119,048	194.01
194.02	07952	FOUNDATION	43,300	1,645	44,945	0	44,945	194.02
200.00		TOTAL (SUM OF LINES 118-199)	8,449,601	10,572,806	19,022,407	0	19,022,407	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	415,906		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-494,217	448,538		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-321,119	1,832,164		4.00
5.01	00540	NONPATIENT TELEPHONES	-4,466	144,137		5.01
5.02	00550	DATA PROCESSING	0	404,697		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	-1	604,264		5.03
5.04	00590	OTHER ADMIN AND GENERAL	-371,639	1,159,562		5.04
7.00	00700	OPERATION OF PLANT	-3,705	517,209		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,288		8.00
9.00	00900	HOUSEKEEPING	0	193,565		9.00
10.00	01000	DIETARY	-10,027	32,576		10.00
11.00	01100	CAFETERIA	-30,067	84,271		11.00
13.00	01300	NURSING ADMINISTRATION	0	280,181		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	32,142		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-35,437	181,460		16.00
17.00	01700	SOCIAL SERVICE	0	52,008		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	95,324		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	772,803		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-244,835	208,544		50.00
53.00	05300	ANESTHESIOLOGY	0	5,648		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,317,565		54.00
60.00	06000	LABORATORY	-4,575	978,063		60.00
65.00	06500	RESPIRATORY THERAPY	-60,870	413,384		65.00
66.00	06600	PHYSICAL THERAPY	-3,615	472,141		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,717		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,314,207		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-40,070	1,441,743		88.00
91.00	09100	EMERGENCY	-985,519	1,292,665		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-469	587,013		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	-154	262,392		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,610,785	15,622,177		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	504,154		192.00
194.00	07950	HOMEBOUND MEALS	0	121,298		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	119,048		194.01
194.02	07952	FOUNDATION	0	44,945		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-2,610,785	16,411,622		200.00

RECLASSIFICATIONS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/23/2016 12:30 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DIETARY COSTS				
1.00	CAFETERIA	11.00	57,106	57,232	1.00
2.00	OTHER ADMIN AND GENERAL	5.04	40,864	40,955	2.00
3.00	HOMEBOUND MEALS	194.00	60,582	60,716	3.00
	0		158,552	158,903	
	B - CRNAS				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	6,647	1.00
	0		0	6,647	
	C - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	31,627	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	31,627	
	D - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	68,288	1.00
	TOTALS		0	68,288	
	E - TELEPHONE				
1.00	NONPATIENT TELEPHONES	5.01	40,622	107,981	1.00
2.00		0.00	0	0	2.00
	TOTALS		40,622	107,981	
	F - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	683	1.00
	TOTALS		0	683	
500.00	Grand Total: Increases		199,174	374,129	500.00

RECLASSIFICATIONS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/23/2016 12:30 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY COSTS						
1.00	DIETARY	10.00	158,552	158,903	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		158,552	158,903			
	B - CRNAS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,647	0		1.00
	0		0	6,647			
	C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.04	0	31,627	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	31,627			
	D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	68,288	0		1.00
	TOTALS		0	68,288			
	E - TELEPHONE						
1.00	DATA PROCESSING	5.02	0	107,981	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	40,622	0	0		2.00
	TOTALS		40,622	107,981			
	F - UTILITIES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	683	0		1.00
	TOTALS		0	683			
500.00	Grand Total: Decreases		199,174	374,129			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	11,496	39,865	0	39,865	0	1.00
2.00	Land Improvements	500,149	8,805	0	8,805	0	2.00
3.00	Buildings and Fixtures	9,053,120	469,718	0	469,718	131,997	3.00
4.00	Building Improvements	275,160	0	0	0	0	4.00
5.00	Fixed Equipment	657,517	6,579	0	6,579	945	5.00
6.00	Movable Equipment	5,745,726	355,545	0	355,545	105,097	6.00
7.00	HIT designated Assets	2,376,213	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,619,381	880,512	0	880,512	238,039	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,619,381	880,512	0	880,512	238,039	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	51,361	0	1.00
2.00	Land Improvements	508,954	0	2.00
3.00	Buildings and Fixtures	9,390,841	0	3.00
4.00	Building Improvements	275,160	0	4.00
5.00	Fixed Equipment	663,151	0	5.00
6.00	Movable Equipment	5,996,174	0	6.00
7.00	HIT designated Assets	2,376,213	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,261,854	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	19,261,854	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/23/2016 12:30 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	398,026	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	929,008	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,327,034	0	0	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	CAP REL COSTS-BLDG & FIXT	0	398,026	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	929,008	2.00
3.00	Total (sum of lines 1-2)	0	1,327,034	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/23/2016 12:30 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,889,467	0	10,889,467	0.565338	17,880	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,372,387	0	8,372,387	0.434662	13,747	2.00
3.00	Total (sum of lines 1-2)	19,261,854	0	19,261,854	1.000000	31,627	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	CAP REL COSTS-BLDG & FIXT	0	0	17,880	398,026	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,747	434,791	0	2.00
3.00	Total (sum of lines 1-2)	0	0	31,627	832,817	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	17,880	0	0	415,906	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,747	0	0	448,538	2.00
3.00	Total (sum of lines 1-2)	0	31,627	0	0	864,444	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/23/2016 12:30 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	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)	A	-3,705	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,312,311			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-30,067	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-35,437	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-10,027	DIETARY	10.00	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	B	-1	CASHIERING/ACCOUNTS RECEIVABLE	5.03	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-494,170	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	ADVERTISING	A	-54,291	OTHER ADMIN AND GENERAL	5.04	0	33.00
33.01	ADVERTISING	A	-469	HOME HEALTH AGENCY	101.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/23/2016 12:30 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	ADVERTISING	A	-405	RURAL HEALTH CLINIC	88.00	0	33.03
33.04	ADVERTISING	A	-154	HOSPICE	116.00	0	33.04
34.00	PHYSICIAN RECRUITMENT	A	-13,264	OTHER ADMIN AND GENERAL	5.04	0	34.00
35.00	WAGE GARNISHMENT FEE	B	-74	OTHER ADMIN AND GENERAL	5.04	0	35.00
36.00	PATIENT PHONE COSTS	A	-47	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01	PATIENT PHONE COSTS	A	-668	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
36.02	PATIENT PHONE COSTS	A	-3,039	NONPATIENT TELEPHONES	5.01	0	36.02
36.03	PATIENT PHONE COSTS	A	-1,427	NONPATIENT TELEPHONES	5.01	0	36.03
37.00	PHYSICIAN BENEFITS	A	-16,081	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
38.00	SELF-INS CASH PMNTS TO HOSPITAL	A	-302,138	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	MISC OTHER OPERATING REVENUE	B	-320	OTHER ADMIN AND GENERAL	5.04	0	39.00
40.00	LEASE REVENUE BUILDINGS	B	-7,150	OTHER ADMIN AND GENERAL	5.04	0	40.00
41.00	LOBBYING	A	-8,427	OTHER ADMIN AND GENERAL	5.04	0	41.00
44.00	MEDICAID TAX	A	-271,601	OTHER ADMIN AND GENERAL	5.04	0	44.00
45.00	SPORTS MEDICINE REVENUE FROM SCHOOLS	B	-3,615	PHYSICAL THERAPY	66.00	0	45.00
45.10	RHC NON-ALLOWABLE SALARIES	A	-39,665	RURAL HEALTH CLINIC	88.00	0	45.10
45.20	RHC NON-ALLOWABLE BENEFITS	A	-2,232	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,610,785				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2016 12:30 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	12,500	4,575	7,925	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	60,870	60,870	0	0	0	2.00
3.00	91.00	EMERGENCY	1,374,887	985,519	389,368	0	0	3.00
4.00	50.00	OPERATING ROOM	244,835	244,835	0	0	0	4.00
5.00	5.04	OTHER ADMIN AND GENERAL	16,512	16,512	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			1,709,604	1,312,311	397,293		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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	5.04	OTHER ADMIN AND GENERAL	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	4,575		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	60,870		2.00
3.00	91.00	EMERGENCY	0	0	0	985,519		3.00
4.00	50.00	OPERATING ROOM	0	0	0	244,835		4.00
5.00	5.04	OTHER ADMIN AND GENERAL	0	0	0	16,512		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	1,312,311		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/23/2016 12:30 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					5	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	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	22.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.42	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)	39.21	39.21	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)					1,745	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,745	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,745	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)					1,745	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)					196	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)					196	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)					28	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					224	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)					224	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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/23/2016 12:30 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		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		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)	78.42	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)	1,745	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	224	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)	1,969	63.00	
64.00	Total cost of outside supplier services (from your records)	1,745	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	196	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	28	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	224	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	28	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	28	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	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141341	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/23/2016 12:30 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		1	1.00
2.00	Line 1 multiplied by 15 hours per week		15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		5	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	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	12.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	80.88	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)	40.44	40.44	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)	1,011	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,011	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	1,011	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)	80.88	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	1,213	22.00
23.00	Total salary equivalency (see instructions)	1,213	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)	202	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)	202	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)	28	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	230	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)	230	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141341	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/23/2016 12:30 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
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		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		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)	80.88	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		1,213	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		230	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)		1,443	63.00
64.00	Total cost of outside supplier services (from your records)		1,011	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		202	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		28	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		230	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		28	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		28	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/23/2016 12:30 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					104	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					5.50	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	251.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	55.55	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)	27.78	27.78	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)					13,957	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					13,957	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)					13,957	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)					55.55	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					43,329	22.00
23.00	Total salary equivalency (see instructions)					43,329	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)					2,889	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)					2,889	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)					572	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,461	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)					3,461	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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/23/2016 12:30 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		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		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)	55.55	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)	43,329	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,461	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)	46,790	63.00
64.00	Total cost of outside supplier services (from your records)	15,747	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	2,889	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	572	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,461	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	572	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	572	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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	415,906	415,906				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	448,538		448,538			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,832,164	0	0	1,832,164		4.00
5.01	00540	NONPATIENT TELEPHONES	144,137	282	603	9,195	154,217	5.01
5.02	00550	DATA PROCESSING	404,697	6,986	28,043	53,534	17,607	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	604,264	8,400	40,696	73,088	10,322	5.03
5.04	00590	OTHER ADMIN AND GENERAL	1,159,562	31,493	42,430	144,419	8,500	5.04
7.00	00700	OPERATION OF PLANT	517,209	109,238	5,612	40,112	1,821	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,288	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	193,565	6,115	0	38,267	607	9.00
10.00	01000	DIETARY	32,576	9,870	5,985	4,817	2,429	10.00
11.00	01100	CAFETERIA	84,271	2,265	0	12,927	0	11.00
13.00	01300	NURSING ADMINISTRATION	280,181	2,995	0	62,658	1,821	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,142	3,699	11	4,479	607	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	181,460	3,030	21,995	32,801	9,714	16.00
17.00	01700	SOCIAL SERVICE	52,008	820	916	10,161	607	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	95,324	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	772,803	38,862	9,296	143,532	18,218	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	208,544	23,143	78,532	24,281	4,857	50.00
53.00	05300	ANESTHESIOLOGY	5,648	0	3,042	0	607	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,317,565	17,732	97,924	105,953	9,107	54.00
60.00	06000	LABORATORY	978,063	5,194	12,018	124,387	3,643	60.00
65.00	06500	RESPIRATORY THERAPY	413,384	16,660	32,542	79,923	5,464	65.00
66.00	06600	PHYSICAL THERAPY	472,141	38,972	13,042	97,845	8,500	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,717	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,314,207	3,830	10,961	40,974	2,429	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,441,743	20,249	13,221	264,166	12,143	88.00
91.00	09100	EMERGENCY	1,292,665	16,660	28,042	181,326	14,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	587,013	8,577	745	107,297	8,500	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	262,392	0	0	36,988	1,214	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,622,177	375,072	445,656	1,693,130	143,289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,127	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	504,154	30,466	1,820	97,761	9,714	192.00
194.00	07950	HOMEBOUND MEALS	121,298	0	0	13,714	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	119,048	8,234	0	17,758	607	194.01
194.02	07952	FOUNDATION	44,945	1,007	1,062	9,801	607	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,411,622	415,906	448,538	1,832,164	154,217	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	
			5.02	5.03	5A.03	5.04	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	510,867					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	50,015	786,785				5.03
5.04	00590	OTHER ADMIN AND GENERAL	35,725	0	1,422,129	1,422,129		5.04
7.00	00700	OPERATION OF PLANT	3,572	0	677,564	64,284	741,848	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	68,288	6,479	0	8.00
9.00	00900	HOUSEKEEPING	3,572	0	242,126	22,972	17,482	9.00
10.00	01000	DIETARY	14,290	0	69,967	6,638	28,216	10.00
11.00	01100	CAFETERIA	0	0	99,463	9,437	6,475	11.00
13.00	01300	NURSING ADMINISTRATION	10,717	0	358,372	34,001	8,561	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,572	0	44,510	4,223	10,575	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,007	0	274,007	25,996	8,662	16.00
17.00	01700	SOCIAL SERVICE	3,572	0	68,084	6,459	2,345	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	95,324	9,044	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,007	33,396	1,041,114	98,776	111,092	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,145	25,878	372,380	35,330	66,158	50.00
53.00	05300	ANESTHESIOLOGY	0	10,588	19,885	1,887	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,870	255,823	1,846,974	175,231	50,690	54.00
60.00	06000	LABORATORY	32,152	183,688	1,339,145	127,051	14,849	60.00
65.00	06500	RESPIRATORY THERAPY	17,862	48,870	614,705	58,320	47,625	65.00
66.00	06600	PHYSICAL THERAPY	46,442	45,277	722,219	68,521	111,408	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,142	11,859	1,125	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,145	66,941	1,446,487	137,235	10,950	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	57,166	0	1,808,688	171,599	57,884	88.00
91.00	09100	EMERGENCY	42,870	114,182	1,690,317	160,369	47,625	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	28,580	0	740,712	70,275	24,518	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	7,145	0	307,739	29,197	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	464,426	786,785	15,382,058	1,324,449	625,115	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	1,127	107	3,223	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,152	0	676,067	64,142	87,093	192.00
194.00	07950	HOMEBOUND MEALS	0	0	135,012	12,809	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	10,717	0	156,364	14,835	23,539	194.01
194.02	07952	FOUNDATION	3,572	0	60,994	5,787	2,878	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	510,867	786,785	16,411,622	1,422,129	741,848	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,767					8.00
9.00	00900	HOUSEKEEPING	0	282,580				9.00
10.00	01000	DIETARY	0	11,007	115,828			10.00
11.00	01100	CAFETERIA	0	2,526	0	117,901		11.00
13.00	01300	NURSING ADMINISTRATION	0	3,340	0	3,733	408,007	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104	4,126	0	946	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,379	0	3,820	0	16.00
17.00	01700	SOCIAL SERVICE	0	915	0	1,281	6,762	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	473	2,494	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,680	43,338	115,828	13,774	72,686	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,636	25,808	0	2,439	12,870	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,614	19,775	0	10,725	56,600	54.00
60.00	06000	LABORATORY	0	5,793	0	12,604	66,512	60.00
65.00	06500	RESPIRATORY THERAPY	592	18,579	0	8,660	45,700	65.00
66.00	06600	PHYSICAL THERAPY	11,686	43,460	0	8,709	45,962	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,271	0	2,774	14,641	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	22,581	0	17,742	0	88.00
91.00	09100	EMERGENCY	28,420	18,579	0	15,876	83,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	9,565	0	1,244	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	1,244	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,732	237,042	115,828	106,044	408,007	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,257	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,975	0	8,112	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	35	9,183	0	2,501	0	194.01
194.02	07952	FOUNDATION	0	1,123	0	1,244	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	74,767	282,580	115,828	117,901	408,007	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
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	64,484					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	354	316,218				16.00
17.00	01700	SOCIAL SERVICE	74	0	85,920			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	107,335		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,105	12,680	68,736	0	1,608,809	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,175	9,825	0	0	534,621	50.00
53.00	05300	ANESTHESIOLOGY	308	4,020	0	107,335	133,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,705	97,131	0	0	2,270,445	54.00
60.00	06000	LABORATORY	17,752	69,742	0	0	1,653,448	60.00
65.00	06500	RESPIRATORY THERAPY	4,451	18,555	0	0	817,187	65.00
66.00	06600	PHYSICAL THERAPY	1,114	17,191	0	0	1,030,270	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,398	813	0	0	17,195	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	360	25,416	0	0	1,642,134	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,696	8,416	0	0	2,089,606	88.00
91.00	09100	EMERGENCY	10,377	43,352	17,184	0	2,115,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,883	5,638	0	0	853,835	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	127	3,439	0	0	341,746	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,879	316,218	85,920	107,335	15,108,610	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	5,714	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,322	0	0	0	870,711	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	147,821	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	277	0	0	0	206,734	194.01
194.02	07952	FOUNDATION	6	0	0	0	72,032	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	64,484	316,218	85,920	107,335	16,411,622	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMIN AND GENERAL				5.04
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,608,809		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	534,621		50.00
53.00	05300	ANESTHESIOLOGY	0	133,435		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,270,445		54.00
60.00	06000	LABORATORY	0	1,653,448		60.00
65.00	06500	RESPIRATORY THERAPY	0	817,187		65.00
66.00	06600	PHYSICAL THERAPY	0	1,030,270		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	17,195		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,642,134		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,089,606		88.00
91.00	09100	EMERGENCY	0	2,115,879		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	853,835		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	341,746		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	15,108,610		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,714		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	870,711		192.00
194.00	07950	HOMEBOUND MEALS	0	147,821		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	206,734		194.01
194.02	07952	FOUNDATION	0	72,032		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	16,411,622		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	282	603	885	0	5.01
5.02	00550	DATA PROCESSING	0	6,986	28,043	35,029	0	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	892	8,400	40,696	49,988	0	5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	31,493	42,430	73,923	0	5.04
7.00	00700	OPERATION OF PLANT	0	109,238	5,612	114,850	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,115	0	6,115	0	9.00
10.00	01000	DIETARY	0	9,870	5,985	15,855	0	10.00
11.00	01100	CAFETERIA	0	2,265	0	2,265	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,995	0	2,995	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,699	11	3,710	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,030	21,995	25,025	0	16.00
17.00	01700	SOCIAL SERVICE	0	820	916	1,736	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	38,862	9,296	48,158	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,504	23,143	78,532	103,179	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	3,042	3,042	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,732	97,924	115,656	0	54.00
60.00	06000	LABORATORY	22,073	5,194	12,018	39,285	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,952	16,660	32,542	55,154	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,972	13,042	52,014	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,666	3,830	10,961	32,457	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	20,249	13,221	33,470	0	88.00
91.00	09100	EMERGENCY	0	16,660	28,042	44,702	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,613	8,577	745	10,935	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	806	0	0	806	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,506	375,072	445,656	871,234	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,127	0	1,127	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,364	30,466	1,820	43,650	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	8,234	0	8,234	0	194.01
194.02	07952	FOUNDATION	0	1,007	1,062	2,069	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	61,870	415,906	448,538	926,314	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	
			5.01	5.02	5.03	5.04	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	885					5.01
5.02	00550	DATA PROCESSING	101	35,130				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	59	3,439	53,486			5.03
5.04	00590	OTHER ADMIN AND GENERAL	49	2,457	0	76,429		5.04
7.00	00700	OPERATION OF PLANT	10	246	0	3,455	118,561	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	348	0	8.00
9.00	00900	HOUSEKEEPING	3	246	0	1,235	2,794	9.00
10.00	01000	DIETARY	14	983	0	357	4,509	10.00
11.00	01100	CAFETERIA	0	0	0	507	1,035	11.00
13.00	01300	NURSING ADMINISTRATION	10	737	0	1,827	1,368	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3	246	0	227	1,690	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	56	1,720	0	1,397	1,384	16.00
17.00	01700	SOCIAL SERVICE	3	246	0	347	375	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	486	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	107	1,720	2,270	5,309	17,755	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28	491	1,759	1,899	10,573	50.00
53.00	05300	ANESTHESIOLOGY	3	0	720	101	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52	2,948	17,389	9,416	8,101	54.00
60.00	06000	LABORATORY	21	2,211	12,488	6,828	2,373	60.00
65.00	06500	RESPIRATORY THERAPY	31	1,228	3,322	3,134	7,611	65.00
66.00	06600	PHYSICAL THERAPY	49	3,194	3,078	3,683	17,807	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	146	60	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14	491	4,551	7,376	1,750	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	70	3,929	0	9,223	9,251	88.00
91.00	09100	EMERGENCY	84	2,948	7,763	8,619	7,611	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	49	1,965	0	3,777	3,918	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	7	491	0	1,569	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	823	31,936	53,486	71,180	99,905	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	6	515	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56	2,211	0	3,447	13,919	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	688	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	3	737	0	797	3,762	194.01
194.02	07952	FOUNDATION	3	246	0	311	460	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	885	35,130	53,486	76,429	118,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	348					8.00
9.00	00900	HOUSEKEEPING	0	10,393				9.00
10.00	01000	DIETARY	0	405	22,123			10.00
11.00	01100	CAFETERIA	0	93	0	3,900		11.00
13.00	01300	NURSING ADMINISTRATION	0	123	0	123	7,183	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	152	0	31	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	124	0	126	0	16.00
17.00	01700	SOCIAL SERVICE	0	34	0	42	119	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	16	44	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110	1,594	22,123	456	1,280	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17	949	0	81	227	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31	727	0	355	996	54.00
60.00	06000	LABORATORY	0	213	0	417	1,171	60.00
65.00	06500	RESPIRATORY THERAPY	3	683	0	286	805	65.00
66.00	06600	PHYSICAL THERAPY	54	1,598	0	288	809	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	157	0	92	258	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	831	0	588	0	88.00
91.00	09100	EMERGENCY	133	683	0	525	1,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	352	0	41	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	41	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	348	8,718	22,123	3,508	7,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	46	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,250	0	268	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	338	0	83	0	194.01
194.02	07952	FOUNDATION	0	41	0	41	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	348	10,393	22,123	3,900	7,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
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	6,059					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33	29,865				16.00
17.00	01700	SOCIAL SERVICE	7	0	2,909			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	546		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	668	1,198	2,327		105,075	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	580	928	0		120,711	50.00
53.00	05300	ANESTHESIOLOGY	29	380	0		4,275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	630	9,161	0		165,462	54.00
60.00	06000	LABORATORY	1,668	6,591	0		73,266	60.00
65.00	06500	RESPIRATORY THERAPY	418	1,753	0		74,428	65.00
66.00	06600	PHYSICAL THERAPY	105	1,625	0		84,304	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	319	77	0		602	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34	2,402	0		49,582	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	253	795	0		58,410	88.00
91.00	09100	EMERGENCY	975	4,097	582		80,196	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	177	533	0		21,747	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	12	325	0		3,251	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,908	29,865	2,909	0	841,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		1,694	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	124	0	0		64,925	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0		688	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	26	0	0		13,980	194.01
194.02	07952	FOUNDATION	1	0	0		3,172	194.02
200.00		Cross Foot Adjustments				546	546	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,059	29,865	2,909	546	926,314	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00590	OTHER ADMIN AND GENERAL				5.04
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	105,075		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	120,711		50.00
53.00	05300	ANESTHESIOLOGY	0	4,275		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	165,462		54.00
60.00	06000	LABORATORY	0	73,266		60.00
65.00	06500	RESPIRATORY THERAPY	0	74,428		65.00
66.00	06600	PHYSICAL THERAPY	0	84,304		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	602		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,582		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	58,410		88.00
91.00	09100	EMERGENCY	0	80,196		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	21,747		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	3,251		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	841,309		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,694		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	64,925		192.00
194.00	07950	HOMEBOUND MEALS	0	688		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	13,980		194.01
194.02	07952	FOUNDATION	0	3,172		194.02
200.00		Cross Foot Adjustments	0	546		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	926,314		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMI NALS)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	82,632					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		434,791				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,093,950			4.00
5.01	00540	NONPATIENT TELEPHONES	56	585	40,622	254		5.01
5.02	00550	DATA PROCESSING	1,388	27,184	236,498	29	143	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,669	39,449	322,880	17	14	5.03
5.04	00590	OTHER ADMIN AND GENERAL	6,257	41,130	637,999	14	10	5.04
7.00	00700	OPERATION OF PLANT	21,703	5,440	177,204	3	1	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,215	0	169,051	1	1	9.00
10.00	01000	DIETARY	1,961	5,802	21,278	4	4	10.00
11.00	01100	CAFETERIA	450	0	57,106	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	595	0	276,806	3	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	735	11	19,788	1	1	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	602	21,321	144,906	16	7	16.00
17.00	01700	SOCIAL SERVICE	163	888	44,888	1	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,721	9,011	634,083	30	7	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,598	76,125	107,267	8	2	50.00
53.00	05300	ANESTHESIOLOGY	0	2,949	0	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,523	94,920	468,070	15	12	54.00
60.00	06000	LABORATORY	1,032	11,650	549,506	6	9	60.00
65.00	06500	RESPIRATORY THERAPY	3,310	31,545	353,077	9	5	65.00
66.00	06600	PHYSICAL THERAPY	7,743	12,642	432,252	14	13	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	761	10,625	181,013	4	2	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,023	12,816	1,166,989	20	16	88.00
91.00	09100	EMERGENCY	3,310	27,183	801,045	24	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,704	722	474,008	14	8	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	163,402	2	2	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,519	431,998	7,479,738	236	130	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	224	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,053	1,764	431,878	16	9	192.00
194.00	07950	HOMEBOUND MEALS	0	0	60,583	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,636	0	78,451	1	3	194.01
194.02	07952	FOUNDATION	200	1,029	43,300	1	1	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	415,906	448,538	1,832,164	154,217	510,867	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.033232	1.031617	0.226362	607.153543	3,572.496503	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	885	35,130	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	3.484252	245.664336	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	
			5.03	5A.04	5.04	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	37,590,349					5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	-1,422,129	14,989,493			5.04
7.00	00700	OPERATION OF PLANT	0	0	677,564	51,559		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	68,288	0	88,716	8.00
9.00	00900	HOUSEKEEPING	0	0	242,126	1,215	0	9.00
10.00	01000	DIETARY	0	0	69,967	1,961	0	10.00
11.00	01100	CAFETERIA	0	0	99,463	450	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	358,372	595	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	44,510	735	123	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	274,007	602	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	68,084	163	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	95,324	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,595,552	0	1,041,114	7,721	28,098	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,236,343	0	372,380	4,598	4,314	50.00
53.00	05300	ANESTHESIOLOGY	505,858	0	19,885	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,223,071	0	1,846,974	3,523	7,848	54.00
60.00	06000	LABORATORY	8,775,882	0	1,339,145	1,032	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,334,805	0	614,705	3,310	702	65.00
66.00	06600	PHYSICAL THERAPY	2,163,146	0	722,219	7,743	13,866	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,355	0	11,859	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,198,193	0	1,446,487	761	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,808,688	4,023	0	88.00
91.00	09100	EMERGENCY	5,455,144	0	1,690,317	3,310	33,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	740,712	1,704	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	307,739	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,590,349	-1,422,129	13,959,929	43,446	88,674	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	1,127	224	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	676,067	6,053	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	135,012	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	156,364	1,636	42	194.01
194.02	07952	FOUNDATION	0	0	60,994	200	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	786,785		1,422,129	741,848	74,767	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.020931		0.094875	14.388332	0.842768	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,486		76,429	118,561	348	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001423		0.005099	2.299521	0.003923	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVIC)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	50,344					9.00
10.00	01000	DIETARY	1,961	4,039				10.00
11.00	01100	CAFETERIA	450	0	197,102			11.00
13.00	01300	NURSING ADMINISTRATION	595	0	6,240	129,251		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	735	0	1,581	0	513,116	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	602	0	6,386	0	2,816	16.00
17.00	01700	SOCIAL SERVICE	163	0	2,142	2,142	589	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	790	790	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,721	4,039	23,026	23,026	56,539	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,598	0	4,077	4,077	49,140	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,523	0	17,930	17,930	53,357	54.00
60.00	06000	LABORATORY	1,032	0	21,070	21,070	141,237	60.00
65.00	06500	RESPIRATORY THERAPY	3,310	0	14,477	14,477	35,417	65.00
66.00	06600	PHYSICAL THERAPY	7,743	0	14,560	14,560	8,863	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	27,041	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	761	0	4,638	4,638	2,866	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,023	0	29,661	0	21,455	88.00
91.00	09100	EMERGENCY	3,310	0	26,541	26,541	82,571	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,704	0	2,080	0	14,986	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	2,080	0	1,014	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,231	4,039	177,279	129,251	500,343	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	224	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,053	0	13,562	0	10,522	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,636	0	4,181	0	2,202	194.01
194.02	07952	FOUNDATION	200	0	2,080	0	49	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	282,580	115,828	117,901	408,007	64,484	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.612983	28.677395	0.598173	3.156703	0.125671	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,393	22,123	3,900	7,183	6,059	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.206440	5.477346	0.019787	0.055574	0.011808	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/23/2016 12:30 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMIN AND GENERAL					5.04
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
16.00	01600	MEDICAL RECORDS & LIBRARY	39,791,485				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,595,552	80	0		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,236,343	0	0		50.00
53.00	05300	ANESTHESIOLOGY	505,858	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,223,071	0	0		54.00
60.00	06000	LABORATORY	8,775,882	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	2,334,805	0	0		65.00
66.00	06600	PHYSICAL THERAPY	2,163,146	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,355	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,198,193	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,059,017	0	0		88.00
91.00	09100	EMERGENCY	5,455,144	20	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	709,431	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	432,688	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,791,485	100	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	HOMEBOUND MEALS	0	0	0		194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0		194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	316,218	85,920	107,335		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.007947	859.200000	1,073.350000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	29,865	2,909	546		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000751	29.090000	5.460000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/23/2016 12:30 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	1,608,809		1,608,809	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	534,621		534,621	0	0	50.00
53.00	05300	ANESTHESIOLOGY	133,435		133,435	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,270,445		2,270,445	0	0	54.00
60.00	06000	LABORATORY	1,653,448		1,653,448	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	817,187	0	817,187	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,030,270	0	1,030,270	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,195		17,195	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,642,134		1,642,134	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,089,606		2,089,606	0	0	88.00
91.00	09100	EMERGENCY	2,115,879		2,115,879	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	185,487		185,487		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	853,835		853,835		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	341,746		341,746		0	116.00
200.00		Subtotal (see instructions)	15,294,097	0	15,294,097	0	0	200.00
201.00		Less Observation Beds	185,487		185,487		0	201.00
202.00		Total (see instructions)	15,108,610	0	15,108,610	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,465,622		1,465,622			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,770	1,202,765	1,207,535	0.442737	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,238	495,139	496,377	0.268818	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	224,460	11,869,247	12,093,707	0.187738	0.000000	54.00
60.00	06000	LABORATORY	363,934	8,331,545	8,695,479	0.190150	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	465,884	1,845,055	2,310,939	0.353617	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	155,039	1,982,806	2,137,845	0.481920	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,711	38,304	102,015	0.168554	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	187,916	3,008,889	3,196,805	0.513680	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,059,017	1,059,017			88.00
91.00	09100	EMERGENCY	272,099	5,145,718	5,417,817	0.390541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	51,780	73,703	125,483	1.478184	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	709,431	709,431			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	432,688	432,688			116.00
200.00		Subtotal (see instructions)	3,256,453	36,194,307	39,450,760			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,256,453	36,194,307	39,450,760			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/23/2016 12:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,608,809		1,608,809	0	1,608,809	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	534,621		534,621	0	534,621	50.00
53.00	05300	ANESTHESIOLOGY	133,435		133,435	0	133,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,270,445		2,270,445	0	2,270,445	54.00
60.00	06000	LABORATORY	1,653,448		1,653,448	0	1,653,448	60.00
65.00	06500	RESPIRATORY THERAPY	817,187	0	817,187	0	817,187	65.00
66.00	06600	PHYSICAL THERAPY	1,030,270	0	1,030,270	0	1,030,270	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,195		17,195	0	17,195	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,642,134		1,642,134	0	1,642,134	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,089,606		2,089,606	0	2,089,606	88.00
91.00	09100	EMERGENCY	2,115,879		2,115,879	0	2,115,879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	185,487		185,487		185,487	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	853,835		853,835		853,835	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	341,746		341,746		341,746	116.00
200.00		Subtotal (see instructions)	15,294,097	0	15,294,097	0	15,294,097	200.00
201.00		Less Observation Beds	185,487		185,487		185,487	201.00
202.00		Total (see instructions)	15,108,610	0	15,108,610	0	15,108,610	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/23/2016 12:30 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,465,622		1,465,622			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,770	1,202,765	1,207,535	0.442737	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,238	495,139	496,377	0.268818	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	224,460	11,869,247	12,093,707	0.187738	0.000000	54.00
60.00	06000	LABORATORY	363,934	8,331,545	8,695,479	0.190150	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	465,884	1,845,055	2,310,939	0.353617	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	155,039	1,982,806	2,137,845	0.481920	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,711	38,304	102,015	0.168554	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	187,916	3,008,889	3,196,805	0.513680	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,059,017	1,059,017	1.973156	0.000000	88.00
91.00	09100	EMERGENCY	272,099	5,145,718	5,417,817	0.390541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	51,780	73,703	125,483	1.478184	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	709,431	709,431			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	432,688	432,688			116.00
200.00		Subtotal (see instructions)	3,256,453	36,194,307	39,450,760			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,256,453	36,194,307	39,450,760			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/23/2016 12:30 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
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
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,711	1,207,535	0.099965	4,721	472	50.00
53.00	05300	ANESTHESIOLOGY	4,275	496,377	0.008612	1,238	11	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	165,462	12,093,707	0.013682	179,571	2,457	54.00
60.00	06000	LABORATORY	73,266	8,695,479	0.008426	264,837	2,232	60.00
65.00	06500	RESPIRATORY THERAPY	74,428	2,310,939	0.032207	412,985	13,301	65.00
66.00	06600	PHYSICAL THERAPY	84,304	2,137,845	0.039434	33,546	1,323	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	602	102,015	0.005901	36,585	216	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,582	3,196,805	0.015510	136,634	2,119	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	58,410	1,059,017	0.055155	0	0	88.00
91.00	09100	EMERGENCY	80,196	5,417,817	0.014802	56,785	841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	16,784	125,483	0.133755	0	0	92.00
200.00		Total (lines 50-199)	728,020	36,843,019		1,126,902	22,972	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	107,335	0	0	0	107,335	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	107,335	0	0	0	107,335	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,207,535	0.000000	0.000000	4,721	50.00
53.00	05300	ANESTHESIOLOGY	0	496,377	0.216237	0.000000	1,238	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,093,707	0.000000	0.000000	179,571	54.00
60.00	06000	LABORATORY	0	8,695,479	0.000000	0.000000	264,837	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,310,939	0.000000	0.000000	412,985	65.00
66.00	06600	PHYSICAL THERAPY	0	2,137,845	0.000000	0.000000	33,546	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	102,015	0.000000	0.000000	36,585	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,196,805	0.000000	0.000000	136,634	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,059,017	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	5,417,817	0.000000	0.000000	56,785	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	125,483	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	36,843,019			1,126,902	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	268	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
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
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	268	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.442737	0	483,961	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.268818	0	202,935	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187738	0	4,344,113	0	0	54.00
60.00	06000	LABORATORY	0.190150	0	3,327,529	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.353617	0	927,004	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.481920	0	684,509	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.168554	0	10,255	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.513680	0	1,908,856	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.390541	0	1,669,312	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.478184	0	73,574	0	0	92.00
200.00		Subtotal (see instructions)		0	13,632,048	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	13,632,048	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	214,267	0		50.00
53.00	05300	ANESTHESIOLOGY	54,553	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	815,555	0		54.00
60.00	06000	LABORATORY	632,730	0		60.00
65.00	06500	RESPIRATORY THERAPY	327,804	0		65.00
66.00	06600	PHYSICAL THERAPY	329,879	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,729	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	980,541	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	651,935	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	108,756	0		92.00
200.00		Subtotal (see instructions)	4,117,749	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,117,749	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141341 | Component CCN: 14Z341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.442737	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.268818	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187738	0	0	0	0	54.00
60.00	06000	LABORATORY	0.190150	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.353617	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.481920	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.168554	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.513680	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.390541	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.478184	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141341 | Component CCN: 14Z341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
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
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,269	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	914	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)	768	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	352	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	3	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)	633	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)	334	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	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,608,809	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)	404	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)	447,606	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,161,203	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)	1,161,203	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,270.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	804,201	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)	804,201	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	347,229	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,151,430	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)	424,334	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)	424,334	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)	146	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,270.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	185,487	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	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	105,075	1,161,203	0.090488	185,487	16,784	90.00
91.00	Nursing School cost	0	1,161,203	0.000000	185,487	0	91.00
92.00	Allied health cost	0	1,161,203	0.000000	185,487	0	92.00
93.00	All other Medical Education	0	1,161,203	0.000000	185,487	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		595,046		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.442737	4,721	2,090	50.00
53.00	05300	ANESTHESIOLOGY	0.268818	1,238	333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187738	179,571	33,712	54.00
60.00	06000	LABORATORY	0.190150	264,837	50,359	60.00
65.00	06500	RESPIRATORY THERAPY	0.353617	412,985	146,039	65.00
66.00	06600	PHYSICAL THERAPY	0.481920	33,546	16,166	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.168554	36,585	6,167	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.513680	136,634	70,186	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.390541	56,785	22,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.478184	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,126,902	347,229	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,126,902		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141341 | Component CCN: 14Z341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/23/2016 12:30 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.442737	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.268818	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187738	18,300	3,436	54.00
60.00	06000	LABORATORY	0.190150	41,372	7,867	60.00
65.00	06500	RESPIRATORY THERAPY	0.353617	41,763	14,768	65.00
66.00	06600	PHYSICAL THERAPY	0.481920	108,476	52,277	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.168554	4,102	691	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.513680	29,805	15,310	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.390541	6,636	2,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.478184	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		250,454	96,941	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)		250,454		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part B Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,117,749	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,117,749	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,158,926	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	37,207	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,084,425	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)	2,037,294	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)	2,037,294	30.00
31.00	Primary payer payments	429	31.00
32.00	Subtotal (line 30 minus line 31)	2,036,865	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)	300,076	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	195,049	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	300,076	36.00
37.00	Subtotal (see instructions)	2,231,914	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)	2,231,914	40.00
40.01	Sequestration adjustment (see instructions)	44,638	40.01
41.00	Interim payments	2,542,872	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-355,596	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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,114,239		2,871,804	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	06/25/2015	132,866		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	03/26/2015	35,110	03/26/2015	13,974	3.50
3.51		09/25/2015	287,538	09/25/2015	179,246	3.51
3.52		12/15/2015	47,959	12/15/2015	135,712	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)		-237,741		-328,932	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)		876,498		2,542,872	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		107,342		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		355,596	6.02
7.00	Total Medicare program liability (see instructions)		983,840		2,187,276	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: 141341 | Component CCN: 14Z341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		536,126		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	03/26/2015	5,103		0	3.50
3.51		09/25/2015	43,389		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)		-48,492		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)		487,634		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		19,680		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		507,314		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: 141341	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/23/2016 12:30 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	283	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	633	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	65	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	768	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	39,450,760	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	67,903	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1	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: 141341 Component CCN: 14Z341	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/23/2016 12:30 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	428,577	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)	97,910	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	334	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)	526,487	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	526,487	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)	526,487	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,820	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)	517,667	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)	517,667	0	19.00
19.01	Sequestration adjustment (see instructions)	10,353	0	19.01
20.00	Interim payments	487,634	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)	19,680	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: 141341	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/23/2016 12:30 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,151,430	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)	1,151,430	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,162,944	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)	1,162,944	19.00
20.00	Deductibles (exclude professional component)	179,338	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	983,606	22.00
23.00	Coinsurance	630	23.00
24.00	Subtotal (line 22 minus line 23)	982,976	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	32,218	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	20,942	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	32,218	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,003,918	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)	1,003,918	30.00
30.01	Sequestration adjustment (see instructions)	20,078	30.01
31.00	Interim payments	876,498	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)	107,342	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/23/2016 12:30 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	12,992,754	0	0	0	1.00
2.00	Temporary investments	4,991,225	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,595,272	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,442,770	0	0	0	6.00
7.00	Inventory	361,421	0	0	0	7.00
8.00	Prepaid expenses	180,814	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	175,319	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,854,035	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	51,361	0	0	0	12.00
13.00	Land improvements	508,954	0	0	0	13.00
14.00	Accumulated depreciation	-234,879	0	0	0	14.00
15.00	Buildings	9,666,001	0	0	0	15.00
16.00	Accumulated depreciation	-5,572,811	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	663,151	0	0	0	19.00
20.00	Accumulated depreciation	-523,593	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	8,372,387	0	0	0	23.00
24.00	Accumulated depreciation	-6,728,945	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	129,514	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,331,140	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	-2,386	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)	-2,386	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,182,789	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	549,772	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,133,580	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				42.00
43.00	Due to other funds	257,824	0	0	0	43.00
44.00	Other current liabilities	384,757	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,325,933	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,325,933	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,856,856				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)	25,856,856	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,182,789	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/23/2016 12:30 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,732,815		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,237,438				2.00
3.00	Total (sum of line 1 and line 2)		25,970,253		0		3.00
4.00	NET INCOME ON INVESTMENT	11,280		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		11,280		0		10.00
11.00	Subtotal (line 3 plus line 10)		25,981,533		0		11.00
12.00	UNREALIZED LOSS ON INVESTMENTS	124,674		0		0	12.00
13.00	ROUNDING	3		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		124,677		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,856,856		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	NET INCOME ON INVESTMENT		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	UNREALIZED LOSS ON INVESTMENTS		0			12.00
13.00	ROUNDING		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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/23/2016 12:30 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,240,879		1,240,879	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	211,200		211,200	5.00
6.00	Swing bed - NF	1,800		1,800	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,453,879		1,453,879	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,453,879		1,453,879	17.00
18.00	Ancillary services	1,466,252	28,736,686	30,202,938	18.00
19.00	Outpatient services	323,879	5,256,748	5,580,627	19.00
20.00	RURAL HEALTH CLINIC	0	1,059,017	1,059,017	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		709,431	709,431	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	432,688	432,688	26.00
27.00	PHYSICIAN	97,842	5,192,528	5,290,370	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,341,852	41,387,098	44,728,950	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,022,407		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	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,022,407		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/23/2016 12:30 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,728,950	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,769,808	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,959,142	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,022,407	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,936,735	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	118,505	6.00
7.00	Income from investments	141,284	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	55,259	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	35,437	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	10,027	21.00
22.00	Rental of hospital space	36,325	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	62,607	24.00
24.01	EHR INCENTIVE PMTS	780,061	24.01
24.02	SPECIALTY CLINIC REVENUE	61,198	24.02
25.00	Total other income (sum of lines 6-24)	1,300,703	25.00
26.00	Total (line 5 plus line 25)	3,237,438	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,237,438	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H

HHA CCN: 147299 | Date/Time Prepared: 5/23/2016 12:30 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		1,613	1,613	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	71,533	0	37,443	0	18,642	127,618	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	227,828	0	0	0	0	227,828	6.00
7.00	Physical Therapy	100,273	0	0	38,152	0	138,425	7.00
8.00	Occupational Therapy	5,919	0	0	5,337	0	11,256	8.00
9.00	Speech Pathology	0	0	0	1,213	0	1,213	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	68,455	0	0	0	0	68,455	11.00
12.00	Supplies (see instructions)	0	0	0	0	11,074	11,074	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)	474,008	0	37,443	44,702	31,329	587,482	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	1,613	0	1,613			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	-469	127,149	0	127,149			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	227,828	0	227,828			6.00
7.00	Physical Therapy	0	138,425	0	138,425			7.00
8.00	Occupational Therapy	0	11,256	0	11,256			8.00
9.00	Speech Pathology	0	1,213	0	1,213			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	68,455	0	68,455			11.00
12.00	Supplies (see instructions)	0	11,074	0	11,074			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)	-469	587,013	0	587,013			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: 141341 | HHA CCN: 147299 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	1,613		1,613			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	127,149	0	1,613	0	0	128,762	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	227,828	0	0	0	0	227,828	6.00
7.00	Physical Therapy	138,425	0	0	0	0	138,425	7.00
8.00	Occupational Therapy	11,256	0	0	0	0	11,256	8.00
9.00	Speech Pathology	1,213	0	0	0	0	1,213	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	68,455	0	0	0	0	68,455	11.00
12.00	Supplies (see instructions)	11,074	0	0	0	0	11,074	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	587,013	0	1,613	0	0	587,013	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	128,762		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	64,016	291,844	6.00
7.00	Physical Therapy	38,895	177,320	7.00
8.00	Occupational Therapy	3,163	14,419	8.00
9.00	Speech Pathology	341	1,554	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	19,235	87,690	11.00
12.00	Supplies (see instructions)	3,112	14,186	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)		587,013	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141341 | HHA CCN: 147299 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-1 Part II | Date/Time Prepared: 5/23/2016 12:30 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		100			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	100	0	0	-128,762	458,251	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	227,828	6.00
7.00	Physical Therapy	0	0	0	0	0	138,425	7.00
8.00	Occupational Therapy	0	0	0	0	0	11,256	8.00
9.00	Speech Pathology	0	0	0	0	0	1,213	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	68,455	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	11,074	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	100	0	0	-128,762	458,251	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	1,613	0	0		128,762	25.00
26.00	Unit Cost Multiplier	0.000000	16.130000	0.000000	0.000000		0.280986	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

HHA CCN: 147299 | Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	8,577	745	16,192	8,500	28,580	1.00
2.00	Skilled Nursing Care	291,844	0	0	51,571	0	0	2.00
3.00	Physical Therapy	177,320	0	0	22,698	0	0	3.00
4.00	Occupational Therapy	14,419	0	0	1,340	0	0	4.00
5.00	Speech Pathology	1,554	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	87,690	0	0	15,496	0	0	7.00
8.00	Supplies (see instructions)	14,186	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)	587,013	8,577	745	107,297	8,500	28,580	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	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.03	5A.03	5.04	7.00	8.00	9.00	
1.00	Administrative and General	0	62,594	5,939	24,518	0	9,565	1.00
2.00	Skilled Nursing Care	0	343,415	32,581	0	0	0	2.00
3.00	Physical Therapy	0	200,018	18,977	0	0	0	3.00
4.00	Occupational Therapy	0	15,759	1,495	0	0	0	4.00
5.00	Speech Pathology	0	1,554	147	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	103,186	9,790	0	0	0	7.00
8.00	Supplies (see instructions)	0	14,186	1,346	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	740,712	70,275	24,518	0	9,565	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

(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: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

HHA CCN: 147299 | Home Health Agency I | PPS

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	14.00	16.00	17.00	
1.00	Administrative and General	0	1,244	0	0	5,638	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	1,883	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	1,244	0	1,883	5,638	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		19.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	109,498	0	109,498			1.00
2.00	Skilled Nursing Care	0	375,996	0	375,996	55,312	431,308	2.00
3.00	Physical Therapy	0	218,995	0	218,995	32,216	251,211	3.00
4.00	Occupational Therapy	0	17,254	0	17,254	2,538	19,792	4.00
5.00	Speech Pathology	0	1,701	0	1,701	250	1,951	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	112,976	0	112,976	16,620	129,596	7.00
8.00	Supplies (see instructions)	0	17,415	0	17,415	2,562	19,977	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	853,835	0	853,835	109,498	853,835	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.					0.147108		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: 141341 HHA CCN: 147299 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-2 Part II Date/Time Prepared: 5/23/2016 12:30 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMI NALS)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVE NUE)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,704	722	71,533	14	8	0	1.00
2.00	Skilled Nursing Care	0	0	227,828	0	0	0	2.00
3.00	Physical Therapy	0	0	100,273	0	0	0	3.00
4.00	Occupational Therapy	0	0	5,919	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	68,455	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)	1,704	722	474,008	14	8	0	20.00
21.00	Total cost to be allocated	8,577	745	107,297	8,500	28,580	0	21.00
22.00	Unit cost multiplier	5.033451	1.031856	0.226361	607.142857	3,572.500000	0.000000	22.00

	Cost Center Description	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5A.04	5.04	7.00	8.00	9.00	10.00	
1.00	Administrative and General	0	62,594	1,704	0	1,704	0	1.00
2.00	Skilled Nursing Care	0	343,415	0	0	0	0	2.00
3.00	Physical Therapy	0	200,018	0	0	0	0	3.00
4.00	Occupational Therapy	0	15,759	0	0	0	0	4.00
5.00	Speech Pathology	0	1,554	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	103,186	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	14,186	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)		740,712	1,704	0	1,704	0	20.00
21.00	Total cost to be allocated		70,275	24,518	0	9,565	0	21.00
22.00	Unit cost multiplier		0.094875	14.388498	0.000000	5.613263	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141341 HHA CCN: 147299

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

Worksheet H-2 Part II Date/Time Prepared: 5/23/2016 12:30 pm

Home Health Agency I

PPS

	Cost Center Description	CAFETERIA (HOURS OF SERVIC)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		11.00	13.00	14.00	16.00	17.00	19.00	
1.00	Administrative and General	2,080	0	0	709,431	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	14,986	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)	2,080	0	14,986	709,431	0	0	20.00
21.00	Total cost to be allocated	1,244	0	1,883	5,638	0	0	21.00
22.00	Unit cost multiplier	0.598077	0.000000	0.125651	0.007947	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

HHA CCN: 147299 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	431,308		431,308	1,704	253.12	1.00
2.00	Physical Therapy	3.00	251,211	0	251,211	2,057	122.12	2.00
3.00	Occupational Therapy	4.00	19,792	0	19,792	115	172.10	3.00
4.00	Speech Pathology	5.00	1,951	0	1,951	8	243.88	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	129,596		129,596	512	253.12	6.00
7.00	Total (sum of lines 1-6)		833,858	0	833,858	4,396		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	821			8.00
9.00	Physical Therapy		99914	0	1,371			9.00
10.00	Occupational Therapy		99914	0	84			10.00
11.00	Speech Pathology		99914	0	8			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	6			13.00
14.00	Total (sum of lines 8-13)			0	2,290			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 Record)	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	19,977	0	19,977	9,935	2.010770	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	821		0	207,812		1.00
2.00	Physical Therapy	0	1,371		0	167,427		2.00
3.00	Occupational Therapy	0	84		0	14,456		3.00
4.00	Speech Pathology	0	8		0	1,951		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	6		0	1,519		6.00
7.00	Total (sum of lines 1-6)	0	2,290		0	393,165		7.00

	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
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 5/23/2016 12:30 pm

HHA CCN: 147299 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	9,935	0	0	19,977	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	207,812	1.00
2.00	Physical Therapy	167,427	2.00
3.00	Occupational Therapy	14,456	3.00
4.00	Speech Pathology	1,951	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	1,519	6.00
7.00	Total (sum of lines 1-6)	393,165	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-3 Part II | Date/Time Prepared: 5/23/2016 12:30 pm

HHA CCN: 147299 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.481920	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.168554	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.513680	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141341 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-4 Part I-II
HHA CCN: 147299 | Date/Time Prepared: 5/23/2016 12:30 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	419,760	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	419,760	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	419,760	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	468,845	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,988	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,856	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,206	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	582	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	485,477	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	485,477	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	485,477	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	485,477	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	485,477	31.00
31.01	Sequestration adjustment (see instructions)	0	9,710	31.01
32.00	Interim payments (see instructions)	0	475,767	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 141341 HHA CCN: 147299 | Period: From 01/01/2015 To 12/31/2015 | Worksheet H-5 Date/Time Prepared: 5/23/2016 12:30 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		475,767	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		475,767	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		475,767	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: 141341 Hospice CCN: 141575 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K | Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		806	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	16,840	0	0	0	0	5.00
6.00	Administrative and General	20,780	0	13,205	0	7,761	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	5,114	0	0	0	0	9.00
10.00	Nursing Care	101,721	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	6,488	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	6,347	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	6,112	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	77,372	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)	163,402	0	13,205	0	85,939	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 141341 Hospice CCN: 141575 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K | Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

		Total (cols. 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.	806	0	806	0	806	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	16,840	0	16,840	0	16,840	5.00
6.00	Administrative and General	41,746	-154	41,592	0	41,592	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	5,114	0	5,114	0	5,114	9.00
10.00	Nursing Care	101,721	0	101,721	0	101,721	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	6,488	0	6,488	0	6,488	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	6,347	0	6,347	0	6,347	18.00
19.00	Home Health Aide and Homemaker	6,112	0	6,112	0	6,112	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	77,372	0	77,372	0	77,372	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)	262,546	-154	262,392	0	262,392	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-1

Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	4,520	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	5,114	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	101,721	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	6,488	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	6,347	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	9,634	12,835	0	101,721	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-1

Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	16,840	16,840		5.00
6.00	Administrative and General		0	16,260	20,780		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	5,114		9.00
10.00	Nursing Care		0	0	101,721		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	6,488		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	6,347		18.00
19.00	Home Health Aide and Homemaker		6,112	0	6,112		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	6,112	33,100	163,402		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-4 Part I Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	806		806			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	16,840	0	0	0	0	5.00
6.00	Administrative and General	41,592	0	806	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	5,114	0	0	0	0	9.00
10.00	Nursing Care	101,721	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	6,488	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	6,347	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	6,112	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	77,372	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)	262,392	0	806	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-4 Part I Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 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	16,840					5.00
6.00	Administrative and General	16,840	59,238	59,238			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	5,114	1,491	6,605		9.00
10.00	Nursing Care	0	101,721	29,661	131,382		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	6,488	1,892	8,380		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	6,347	1,851	8,198		18.00
19.00	Home Health Aide and Homemaker	0	6,112	1,782	7,894		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	77,372	22,561	99,933		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	16,840	262,392		262,392		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141341 Hospice CCN: 141575 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-4 Part II Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		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	100				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	100	5.00
6.00	Administrative and General	0	100	0	0	100	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	806	0	0	16,840	39.00
40.00	Unit Cost Multiplier	0.000000	8.060000	0.000000	0.000000	168.400000	40.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141341 Hospice CCN: 141575 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-4 Part II Date/Time Prepared: 5/23/2016 12:30 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	-59,238	203,154		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	5,114		9.00
10.00	Nursing Care	0	101,721		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	6,488		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	6,347		18.00
19.00	Home Health Aide and Homemaker	0	6,112		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	77,372		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)		59,238		39.00
40.00	Unit Cost Multiplier		0.291592		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-5 Part I Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		0	1.00	2.00	4.00	5.01	
1.00	Administrative and General		0	0	36,988	1,214	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	6,605	0	0	0	0	4.00
5.00	Nursing Care	131,382	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	8,380	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	8,198	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	7,894	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	99,933	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)	262,392	0	0	36,988	1,214	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141341
Hospice CCN: 141575

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

Worksheet K-5
Part I
Date/Time Prepared:
5/23/2016 12:30 pm

Hospice I

	Cost Center Description	DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	
		5.02	5.03	5A.03	5.04	7.00	
1.00	Administrative and General	7,145	0	45,347	4,302	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	6,605	627	0	4.00
5.00	Nursing Care	0	0	131,382	12,465	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	8,380	795	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	8,198	778	0	13.00
14.00	Home Health Aide and Homemaker	0	0	7,894	749	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	99,933	9,481	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)	7,145	0	307,739	29,197	0	34.00
35.00	Unit Cost Multiplier (see instructions)			0.000000			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-5 Part I Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	1,244	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	1,244	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141341
Hospice CCN: 141575

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

Worksheet K-5
Part I
Date/Time Prepared:
5/23/2016 12:30 pm

Hospice I

	Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal (cols. 4A-23)	
		14.00	16.00	17.00	19.00	24.00	
1.00	Administrative and General	127	3,439	0	0	54,459	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	7,232	4.00
5.00	Nursing Care	0	0	0	0	143,847	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	9,175	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	8,976	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	8,643	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	109,414	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)	127	3,439	0	0	341,746	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-5 Part I Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	7,232	1,371	8,603		4.00
5.00	Nursing Care	0	143,847	27,268	171,115		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	9,175	1,739	10,914		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	8,976	1,702	10,678		13.00
14.00	Home Health Aide and Homemaker	0	8,643	1,638	10,281		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	109,414	20,741	130,155		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	341,746		341,746		34.00
35.00	Unit Cost Multiplier (see instructions)			0.189563			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141341 | Hospice CCN: 141575 | Period: From 01/01/2015 To 12/31/2015 | Worksheet K-5 Part II | Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMI NALS)	
		1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	0	163,402	2	2	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	163,402	2	2	34.00
35.00	Total cost to be allocated	0	0	36,988	1,214	7,145	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.226362	607.000000	3,572.500000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141341
Hospice CCN: 141575

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

Worksheet K-5
Part II
Date/Time Prepared:
5/23/2016 12:30 pm

Hospice I

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	
		5.03	5A.04	5.04	7.00	8.00	
1.00	Administrative and General	0	0	45,347	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	6,605	0	0	4.00
5.00	Nursing Care	0	0	131,382	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	8,380	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	8,198	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	7,894	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	99,933	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		307,739	0	0	34.00
35.00	Total cost to be allocated	0		29,197	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000		0.094876	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141341
Hospice CCN: 141575

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

Worksheet K-5
Part II
Date/Time Prepared:
5/23/2016 12:30 pm

Hospice I

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVIC)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	2,080	0	1,014	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	2,080	0	1,014	34.00
35.00	Total cost to be allocated	0	0	1,244	0	127	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.598077	0.000000	0.125247	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 141341
Hospice CCN: 141575

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

Worksheet K-5
Part II
Date/Time Prepared:
5/23/2016 12:30 pm

Hospice I

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		16.00	17.00	19.00		
1.00	Administrative and General	432,688	0	0		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	432,688	0	0		34.00
35.00	Total cost to be allocated	3,439	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.007948	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-5 Part III Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.481920	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.513680	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.190150	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.168554	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 141341 Hospice CCN: 141575

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

Worksheet K-6

Date/Time Prepared: 5/23/2016 12:30 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				341,746	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				0	2.00
3.00	Average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	0				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	0				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 141341 Component CCN: 148508 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/23/2016 12:30 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	715,917	0	715,917	0	715,917	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	146,552	0	146,552	0	146,552	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	194,187	0	194,187	0	194,187	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)	1,056,656	0	1,056,656	0	1,056,656	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	27,287	27,287	0	27,287	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	27,287	27,287	0	27,287	14.00
15.00	Medical Supplies	0	87,455	87,455	0	87,455	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	36,860	36,860	0	36,860	18.00
19.00	Other Health Care Costs	0	2,948	2,948	0	2,948	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	127,263	127,263	0	127,263	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,056,656	154,550	1,211,206	0	1,211,206	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
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	37,737	37,737	0	37,737	29.00
30.00	Administrative Costs	149,998	82,872	232,870	0	232,870	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	149,998	120,609	270,607	0	270,607	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,206,654	275,159	1,481,813	0	1,481,813	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 141341 | Component CCN: 148508 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/23/2016 12:30 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	-39,665	676,252		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	146,552		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	194,187		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)	-39,665	1,016,991		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	27,287		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	27,287		14.00
15.00	Medical Supplies	0	87,455		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	36,860		18.00
19.00	Other Health Care Costs	0	2,948		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	127,263		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-39,665	1,171,541		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
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	37,737		29.00
30.00	Administrative Costs	-405	232,465		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-405	270,202		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-40,070	1,441,743		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141341 | Component CCN: 148508 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2 | Date/Time Prepared: 5/23/2016 12:30 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	2.11	8,678	4,200	8,862		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.02	2,510	2,100	2,142		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.13	11,188		11,004	11,188	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)	3.13	11,188			11,188	8.00
9.00	Physician Services Under Agreements		0			0	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)					1,171,541	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)					1,171,541	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)					270,202	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					647,863	15.00
16.00	Total overhead (sum of lines 14 and 15)					918,065	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					918,065	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					918,065	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,089,606	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141341 | Component CCN: 148508 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-3 | Date/Time Prepared: 5/23/2016 12:30 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)		2,089,606	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		52,310	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,037,296	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		11,188	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		11,188	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		182.10	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on 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)	182.10	182.10	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,727	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	496,587	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) *		496,587	16.00
16.01	Total program charges (see instructions)(from contractor's records)		318,751	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		4,795	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,470	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.)		364,709	16.04
16.05	Total program cost (see instructions)		372,179	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,231	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		56,145	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		372,179	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		14,407	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		386,586	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)		386,586	26.00
26.01	Sequestration adjustment (see instructions)		7,732	26.01
27.00	Interim payments		284,323	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)		94,531	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: 141341 Component CCN: 148508	Period: From 01/01/2015 To 12/31/2015	Worksheet M-4 Date/Time Prepared: 5/23/2016 12:30 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)	1,016,991	1,016,991	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000572	0.002078	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	582	2,113	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	17,899	8,734	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	18,481	10,847	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,171,541	1,171,541	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	918,065	918,065	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015775	0.009259	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	14,482	8,500	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	32,963	19,347	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	154	560	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	214.05	34.55	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	46	132	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,846	4,561	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)		52,310	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)		14,407	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141341 Component CCN: 148508	Period: From 01/01/2015 To 12/31/2015	Worksheet M-5 Date/Time Prepared: 5/23/2016 12:30 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		285,914	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		03/26/2015	1,591	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)		-1,591	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		284,323	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		94,531	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		378,854	7.00

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