

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

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider No.: 145269

Period:
 From 12/01/2014
 To 11/30/2015

Worksheet S
 Parts I, II & III
 Date/Time Prepared:
 5/2/2016 3:28 pm

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report

Contractor use only
 4. Cost Report Status
 (1) As Submitted
 (2) Settled without audit
 (3) Settled with audit
 (4) Reopened
 (5) Amended

5. Date Received:
 6. Contractor No.
 7. First Cost Report for this Provider CCN
 8. Last Cost Report for this Provider CCN
 9. NPR Date:
 10. If line 4, column 1 is "4": Enter number of times reopened
 11. Contractor Vendor Code 4

Date: 5/2/2016 Time: 3:28 pm

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 Hope Creek Care Center (145269) for the cost reporting period beginning 12/01/2014 and ending 11/30/2015 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.

Officer or Administrator of Provider(s)

Printed Name _____ Signed _____

Title _____ Date _____

Cost Center Description	Title V 1.00	Title XVIII		Title XIX 4.00	
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 SKILLED NURSING FACILITY	0	-27,360	0	0	1.00
2.00 NURSING FACILITY	0			0	2.00
3.00 ICF/MR				0	3.00
4.00 SNF - BASED HHA I	0	0	0		4.00
5.00 SNF - BASED RHC I	0		0		5.00
6.00 SNF - BASED FOHC I	0		0		6.00
7.00 SNF - BASED CMHC I	0		0		7.00
7.10 SNF - BASED CORF I	0		0		7.10
100.00 TOTAL	0	-27,360	0	0	100.00

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.

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet S-2 Part I Date/Time Prepared: 5/2/2016 3:22 pm				
1.00		2.00		3.00				
Skilled Nursing Facility and Skilled Nursing Facility Complex Address:								
1.00	Street: 4343 Kennedy Drive	PO Box:				1.00		
2.00	City: East Moline	State: IL	Zip Code: 61244			2.00		
3.00	County: Rock Island	CBSA Code: 19340	Urban/Rural: U			3.00		
3.01		CBSA Code: 19340				3.01		
		Component Name	Provider CCN	Date Certified	Payment System (P, O, or N)			
					V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	
SNF and SNF-Based Component Identification:								
4.00	SNF	Hope Creek Care Center	145269	10/01/1997	N	P	N	
5.00	Nursing Facility							
6.00	ICF/MR							
7.00	SNF-Based HHA							
8.00	SNF-Based RHC							
9.00	SNF-Based FOHC							
10.00	SNF-Based CMHC							
11.00	SNF-Based OLTC							
12.00	SNF-Based HOSPICE							
13.00	SNF-Based CORF							
				From:	To:			
				1.00	2.00			
14.00	Cost Reporting Period (mm/dd/yy)			12/01/2014	11/30/2015		14.00	
15.00	Type of Control (See Instructions)				9		15.00	
					Y/N			
					1.00			
Type of Freestanding Skilled Nursing Facility								
16.00	Is this a distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					Y		16.00
17.00	Is this a composite distinct part skilled nursing facility that meets the requirements set forth in 42 CFR section 483.5?					N		17.00
18.00	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.					Y		18.00
Miscellaneous Cost Reporting Information								
19.00	If this is a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.00
19.01	If line 19 is yes, does this cost report meet your contractor's criteria for filing a low Medicare utilization cost report, indicate with a "Y", for yes, or "N" for no.					N		19.01
Depreciation - Enter the amount of depreciation reported in this SNF for the method indicated on Lines 20 - 22.								
20.00	Straight Line					573,444		20.00
21.00	Declining Balance					0		21.00
22.00	Sum of the Year's Digits					0		22.00
23.00	Sum of line 20 through 22					573,444		23.00
24.00	If depreciation is funded, enter the balance as of the end of the period.					0		24.00
25.00	Were there any disposal of capital assets during the cost reporting period? (Y/N)					N		25.00
26.00	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period? (Y/N)					N		26.00
27.00	Did you cease to participate in the Medicare program at end of the period to which this cost report applies? (Y/N)					N		27.00
28.00	Was there a substantial decrease in health insurance proportion of allowable cost from prior cost reports? (Y/N)					N		28.00
				Part A	Part B	Other		
				1.00	2.00	3.00		
29.00	If this facility contains a public or non-public provider that qualifies for an exemption from the application of the lower of the costs or charges enter "Y" for each component and type of service that qualifies for the exemption.					N	N	N
30.00	Skilled Nursing Facility							
31.00	Nursing Facility							
32.00	ICF/MR							
33.00	SNF-Based HHA					N	N	
34.00	SNF-Based RHC						N	
35.00	SNF-Based FOHC							
36.00	SNF-Based CMHC						N	
36.00	SNF-Based OLTC							
				Y/N				
				1.00	2.00			
37.00	Is the skilled nursing facility located in a state that certifies the provider as a SNF regardless of the level of care given for Titles V & XIX patients? (Y/N)					Y		37.00
38.00	Are you legally-required to carry malpractice insurance? (Y/N)					N		38.00
39.00	Is the malpractice a "claims-made" or "occurrence" policy? If the policy is "claims-made" enter 1. If the policy is "occurrence", enter 2.							39.00
			Premiums	Paid Losses	Self Insurance			
			1.00	2.00	3.00			
41.00	List malpractice premiums and paid losses:		0	0	0		41.00	

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet S-2 Part I Date/Time Prepared: 5/2/2016 3:22 pm
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		Y/N	
		1.00	
42.00	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? Enter Y or N. If yes, check box, and submit supporting schedule listing cost centers and amounts.	N	42.00
43.00	Are there any home office costs as defined in CMS Pub. 15-1, Chapter 10?	N	43.00
44.00	If line 43 is yes, enter the home office chain number and enter the name and address of the home office on lines 45, 46 and 47.		44.00
		1.00	2.00
			3.00
	If this facility is part of a chain organization, enter the name and address of the home office on the lines below.		
45.00	Name:	Contractor's Name:	Contractor's Number:
46.00	Street:	PO Box:	
47.00	City:	State:	Zip Code:

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE		Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet S-2 Part II Date/Time Prepared: 5/2/2016 3:22 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: For all column 1 responses enter in column 1, "Y" for Yes or "N" for No. For all the date responses the format will be (mm/dd/yyyy)					
Completed by All Skilled Nursing Facilities					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If column 1 is "Y", 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 column 1 is yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? (Y/N) 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 column 1 is "Y", submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column 2: Is the provider the legal operator of the program? (Y/N)	N		N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instructions.	N			7.00
8.00	Were approvals and/or renewals obtained during the cost reporting period for Nursing School and/or Allied Health Program? (Y/N) see instructions.	N			8.00
		Y/N			
		1.00			
Bad Debts					
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see instructions.			Y	9.00
10.00	If line 9 is "Y", did the provider's bad debt collection policy change during this cost reporting period? If "Y", submit copy.			N	10.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived? If "Y", see instructions.			N	11.00
Bed Complement					
12.00	Have total beds available changed from prior cost reporting period? If "Y", see instructions.			N	12.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)	Y	04/26/2016	N	13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.	N		N	14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.	N		N	15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.	N		N	16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:	N/A		N	17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.	N		N	18.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX REIMBURSEMENT QUESTIONNAIRE

Provider No. : 145269

Period:
 From 12/01/2014
 To 11/30/2015

Worksheet S-2
 Part II
 Date/Time Prepared:
 5/2/2016 3:22 pm

		Part B	
		Date	
		4.00	
PS&R Data			
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or 3 is "Y", enter the paid through date of the PS&R used to prepare this cost report in cols. 2 and 4. (see Instructions.)		13.00
14.00	Was the cost report prepared using the PS&R for total and the provider's records for allocation? If either col. 1 or 3 is "Y" enter the paid through date of the PS&R used to prepare this cost report in columns 2 and 4.		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for additional claims that have been billed but are not included on the PS&R used to file this cost report? If "Y", see Instructions.		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for corrections of other PS&R Report information? If yes, see instructions.		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for Other? Describe the other adjustments:		17.00
18.00	Was the cost report prepared only using the provider's records? If "Y" see Instructions.		18.00

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE
 COMPLEX STATISTICAL DATA

Provider No. : 145269

Period:
 From 12/01/2014
 To 11/30/2015

Worksheet S-3
 Part I
 Date/Time Prepared:
 5/2/2016 3:22 pm

Component		Number of Beds	Bed Days Available	Inpatient Days/Visits			
				Title V	Title XVIII	Title XIX	
				1.00	2.00	3.00	
1.00	SKILLED NURSING FACILITY	245	89,425	0	6,238	41,997	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/MR	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
6.10	SNF-Based CORF	0	0	0	0	0	6.10
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	245	89,425	0	6,238	41,997	8.00
Component		Inpatient Days/Visits		Discharges			
		Other	Total	Title V	Title XVIII	Title XIX	
		6.00	7.00	8.00	9.00	10.00	
1.00	SKILLED NURSING FACILITY	29,075	77,310	0	106	16	1.00
2.00	NURSING FACILITY	0	0	0	0	0	2.00
3.00	ICF/MR	0	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0	0	0	4.00
5.00	Other Long Term Care	0	0	0	0	0	5.00
6.00	SNF-Based CMHC	0	0	0	0	0	6.00
6.10	SNF-Based CORF	0	0	0	0	0	6.10
7.00	HOSPICE	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	29,075	77,310	0	106	16	8.00
Component		Discharges		Average Length of Stay			
		Other	Total	Title V	Title XVIII	Title XIX	
		11.00	12.00	13.00	14.00	15.00	
1.00	SKILLED NURSING FACILITY	25	147	0.00	58.85	2,624.81	1.00
2.00	NURSING FACILITY	0	0	0.00	0.00	0.00	2.00
3.00	ICF/MR	0	0	0.00	0.00	0.00	3.00
4.00	HOME HEALTH AGENCY COST	0	0	0.00	0.00	0.00	4.00
5.00	Other Long Term Care	0	0	0.00	0.00	0.00	5.00
6.00	SNF-Based CMHC	0	0	0.00	0.00	0.00	6.00
6.10	SNF-Based CORF	0	0	0.00	0.00	0.00	6.10
7.00	HOSPICE	0	0	0.00	0.00	0.00	7.00
8.00	Total (Sum of lines 1-7)	25	147	0.00	58.85	2,624.81	8.00
Component		Average Length of Stay		Admissions			
		Total	Title V	Title XVIII	Title XIX	Other	
		16.00	17.00	18.00	19.00	20.00	
1.00	SKILLED NURSING FACILITY	525.92	0	152	47	111	1.00
2.00	NURSING FACILITY	0.00	0	0	0	0	2.00
3.00	ICF/MR	0.00	0	0	0	0	3.00
4.00	HOME HEALTH AGENCY COST	0.00	0	0	0	0	4.00
5.00	Other Long Term Care	0.00	0	0	0	0	5.00
6.00	SNF-Based CMHC	0.00	0	0	0	0	6.00
6.10	SNF-Based CORF	0.00	0	0	0	0	6.10
7.00	HOSPICE	0.00	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	525.92	0	152	47	111	8.00
Component		Admissions		Full Time Equivalent			
		Total	Employees on Payroll	Nonpaid Workers			
		21.00	22.00	23.00			
1.00	SKILLED NURSING FACILITY	310	244.88	0.00	0.00	1.00	
2.00	NURSING FACILITY	0	0.00	0.00	0.00	2.00	
3.00	ICF/MR	0	0.00	0.00	0.00	3.00	
4.00	HOME HEALTH AGENCY COST	0	0.00	0.00	0.00	4.00	
5.00	Other Long Term Care	0	0.00	0.00	0.00	5.00	
6.00	SNF-Based CMHC	0	0.00	0.00	0.00	6.00	
6.10	SNF-Based CORF	0	0.00	0.00	0.00	6.10	
7.00	HOSPICE	0	0.00	0.00	0.00	7.00	
8.00	Total (Sum of lines 1-7)	310	244.88	0.00	0.00	8.00	

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet S-3
Part II
Date/Time Prepared:
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	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART II - DIRECT SALARIES						
SALARIES						
1.00	Total salaries (See Instructions)	8,230,258	0	8,230,258	509,358.00	16.16
2.00	Physician salaries-Part A	0	0	0	0.00	0.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00
4.00	Home office personnel	0	0	0	0.00	0.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00
6.00	Revised wages (line 1 minus line 5)	8,230,258	0	8,230,258	509,358.00	16.16
7.00	Other Long Term Care	0	0	0	0.00	0.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00
9.00	CMHC	0	0	0	0.00	0.00
9.10	CORF					
10.00	HOSPICE	0	0	0	0.00	0.00
11.00	Other excluded areas	0	0	0	0.00	0.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	8,230,258	0	8,230,258	509,358.00	16.16
OTHER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	1,638,859	0	1,638,859	36,747.00	44.60
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00
WAGE-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	3,126,359	0	3,126,359		
18.00	Wage-related costs other (See Part IV)	0	0	0		
19.00	Wage related costs (excluded units)	0	0	0		
20.00	Physician Part A - WRC	0	0	0		
21.00	Physician Part B - WRC	0	0	0		
22.00	Total Adjusted Wage Related cost (see instructions)	3,126,359	0	3,126,359		

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet S-3
Part III
Date/Time Prepared:
5/2/2016 3:22 pm

	Amount Reported	Reclass. of Salaries from Worksheet A-6	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
	1.00	2.00	3.00	4.00	5.00	
PART III - OVERHEAD COST - DIRECT SALARIES						
1.00	Employee Benefits	0	0	0.00	0.00	1.00
2.00	Administrative & General	329,387	0	329,387	16,000.00	2.00
3.00	Plant Operation, Maintenance & Repairs	217,450	0	217,450	10,226.00	3.00
4.00	Laundry & Linen Service	294,076	0	294,076	19,684.00	4.00
5.00	Housekeeping	298,583	0	298,583	22,249.00	5.00
6.00	Dietary	765,530	0	765,530	54,209.00	6.00
7.00	Nursing Administration	0	46,571	46,571	1,353.00	7.00
8.00	Central Services and Supply	0	0	0	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	9.00
10.00	Medical Records & Medical Records Library	0	0	0	0.00	10.00
11.00	Social Service	535,631	0	535,631	34,692.00	11.00
12.00	Nursing and Allied Health Ed. Act.	0	0	0	0.00	12.00
13.00	Other General Service	0	0	0	0.00	13.00
14.00	Total (sum lines 1 thru 13)	2,440,657	46,571	2,487,228	158,413.00	14.00

SNF WAGE RELATED COSTS	Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 5/2/2016 3:22 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	831,443	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	1,684,660	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	610,256	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 - 23)	3,126,359	24.00
Part B - Other than Core Related Cost			
25.00	Other Wage Related Cost (Non Core)	0	25.00

SNF REPORTING OF DIRECT CARE EXPENDITURES

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet S-3
Part V
Date/Time Prepared:
5/2/2016 3:22 pm

Occupational Category		Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Direct Salaries							
Nursing Occupations							
1.00	Registered Nurses (RNs)	542,009	209,048	751,057	23,942.00	31.37	1.00
2.00	Licensed Practical Nursed (LPNs)	1,572,612	606,541	2,179,153	81,816.00	26.63	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	3,340,334	1,288,334	4,628,668	230,445.00	20.09	3.00
4.00	Total Nursing (sum of lines 1 through 3)	5,454,955	2,103,923	7,558,878	336,203.00	22.48	4.00
5.00	Physical Therapists	0	0	0	0.00	0.00	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	0	0	0	0.00	0.00	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	150,898	58,200	209,098	8,816.00	23.72	10.00
11.00	Speech Therapists	0	0	0	0.00	0.00	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contract Labor							
Nursing Occupations							
14.00	Registered Nurses (RNs)	76,174		76,174	1,810.00	42.09	14.00
15.00	Licensed Practical Nursed (LPNs)	127,455		127,455	3,769.00	33.82	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	428,065		428,065	18,758.00	22.82	16.00
17.00	Total Nursing (sum of lines 14 through 16)	631,694		631,694	24,337.00	25.96	17.00
18.00	Physical Therapists	379,187		379,187	5,097.00	74.39	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	383,675		383,675	4,358.00	88.04	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	244,303		244,303	2,955.00	82.67	24.00
25.00	Respiratory Therapists	0		0	0.00	0.00	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet S-7

Date/Time Prepared:
5/2/2016 3:22 pm

	Group	Days		
		1. 00	2. 00	
1. 00	RUX		0	1. 00
2. 00	RUL		221	2. 00
3. 00	RVX		28	3. 00
4. 00	RVL		25	4. 00
5. 00	RHX		14	5. 00
6. 00	RHL		25	6. 00
7. 00	RMX		0	7. 00
8. 00	RML		0	8. 00
9. 00	RLX		0	9. 00
10. 00	RUC		1, 162	10. 00
11. 00	RUB		751	11. 00
12. 00	RUA		2, 283	12. 00
13. 00	RVC		464	13. 00
14. 00	RVB		179	14. 00
15. 00	RVA		440	15. 00
16. 00	RHC		141	16. 00
17. 00	RHB		35	17. 00
18. 00	RHA		204	18. 00
19. 00	RMC		0	19. 00
20. 00	RMB		7	20. 00
21. 00	RMA		18	21. 00
22. 00	RLB		0	22. 00
23. 00	RLA		0	23. 00
24. 00	ES3		0	24. 00
25. 00	ES2		0	25. 00
26. 00	ES1		0	26. 00
27. 00	HE2		0	27. 00
28. 00	HE1		0	28. 00
29. 00	HD2		3	29. 00
30. 00	HD1		14	30. 00
31. 00	HC2		0	31. 00
32. 00	HC1		0	32. 00
33. 00	HB2		0	33. 00
34. 00	HB1		16	34. 00
35. 00	LE2		0	35. 00
36. 00	LE1		0	36. 00
37. 00	LD2		0	37. 00
38. 00	LD1		0	38. 00
39. 00	LC2		0	39. 00
40. 00	LC1		11	40. 00
41. 00	LB2		0	41. 00
42. 00	LB1		17	42. 00
43. 00	CE2		30	43. 00
44. 00	CE1		6	44. 00
45. 00	CD2		1	45. 00
46. 00	CD1		44	46. 00
47. 00	CC2		4	47. 00
48. 00	CC1		0	48. 00
49. 00	CB2		0	49. 00
50. 00	CB1		29	50. 00
51. 00	CA2		0	51. 00
52. 00	CA1		0	52. 00
53. 00				53. 00
54. 00				54. 00
55. 00				55. 00
56. 00				56. 00
57. 00				57. 00
58. 00				58. 00
59. 00				59. 00
60. 00				60. 00
61. 00				61. 00
62. 00				62. 00
63. 00	BB2		0	63. 00
64. 00	BB1		4	64. 00
65. 00	BA2		0	65. 00
66. 00	BA1		0	66. 00
67. 00	PE2		0	67. 00
68. 00	PE1		0	68. 00
69. 00	PD2		0	69. 00
70. 00	PD1		9	70. 00
71. 00	PC2		0	71. 00
72. 00	PC1		0	72. 00
73. 00	PB2		0	73. 00
74. 00	PB1		0	74. 00
75. 00	PA2		0	75. 00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet S-7

Date/Time Prepared:
5/2/2016 3:22 pm

		Group	Days	
		1.00	2.00	
76.00		PA1		1 76.00
99.00		AAA		52 99.00
100.00	TOTAL			6,238 100.00
		Expenses	Percentage	Y/N
		1.00	2.00	3.00
<p>A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)</p>				
101.00	Staffing	6,257,634	46.07	Y 101.00
102.00	Recruitment	0	0.00	N/A 102.00
103.00	Retention of employees	0	0.00	N/A 103.00
104.00	Training	0	0.00	N/A 104.00
105.00	OTHER (SPECIFY)	0	0.00	N/A 105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)		13,583,230	106.00

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet A Date/Time Prepared: 5/2/2016 3:22 pm	
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications Increase/Decrease (Fr Wkst 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		645,787	645,787	0	645,787
2.00	00200		0	0	0	0
3.00	00300	0	3,174,329	3,174,329	0	3,174,329
4.00	00400	329,387	2,206,947	2,536,334	0	2,536,334
5.00	00500	217,450	509,650	727,100	0	727,100
6.00	00600	294,076	23,405	317,481	0	317,481
7.00	00700	298,583	78,701	377,284	0	377,284
8.00	00800	765,530	641,593	1,407,123	0	1,407,123
9.00	00900	0	0	0	46,571	46,571
10.00	01000	0	355,043	355,043	0	355,043
11.00	01100	0	0	0	0	0
12.00	01200	0	0	0	0	0
13.00	01300	535,631	7,897	543,528	0	543,528
14.00	01400	0	0	0	0	0
15.00	01500	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	5,638,703	665,502	6,304,205	-46,571	6,257,634
31.00	03100	0	0	0	0	0
32.00	03200	0	0	0	0	0
33.00	03300	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
40.00	04000	0	300	300	0	300
41.00	04100	0	20,189	20,189	0	20,189
42.00	04200	0	0	0	0	0
43.00	04300	0	28,206	28,206	0	28,206
44.00	04400	0	379,187	379,187	0	379,187
45.00	04500	150,898	393,127	544,025	0	544,025
46.00	04600	0	244,303	244,303	0	244,303
47.00	04700	0	0	0	0	0
48.00	04800	0	93,858	93,858	0	93,858
49.00	04900	0	378,744	378,744	0	378,744
50.00	05000	0	0	0	0	0
51.00	05100	0	0	0	0	0
52.00	05200	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	0	0	0	0	0
61.00	06100	0	0	0	0	0
62.00	06200	0	0	0	0	0
63.00	06300	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
70.00	07000	0	0	0	0	0
71.00	07100	0	0	0	0	0
72.00	07200	0	0	0	0	0
73.00	07300	0	0	0	0	0
74.00	07400	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
80.00	08000	0	0	0	0	0
81.00	08100	0	0	0	0	0
82.00	08200	0	0	0	0	0
83.00	08300	0	0	0	0	0
84.00	08400	0	0	0	0	0
89.00		8,230,258	9,846,768	18,077,026	0	18,077,026
NONREIMBURSABLE COST CENTERS						
90.00	09000	0	0	0	0	0
91.00	09100	0	0	0	0	0
92.00	09200	0	0	0	0	0
93.00	09300	0	0	0	0	0
94.00	09400	0	0	0	0	0
95.00	09500	0	0	0	0	0
100.00		8,230,258	9,846,768	18,077,026	0	18,077,026

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet A
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description		Adjustments to Expenses (Fr Wkst A-8)	Net Expenses For Allocation (col. 5 +- col. 6)		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES	569,788	1,215,575	1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT	0	0	2.00
3.00	00300	EMPLOYEE BENEFITS	81,237	3,255,566	3.00
4.00	00400	ADMINISTRATIVE & GENERAL	-157,628	2,378,706	4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	208	727,308	5.00
6.00	00600	LAUNDRY & LINEN SERVICE	0	317,481	6.00
7.00	00700	HOUSEKEEPING	0	377,284	7.00
8.00	00800	DIETARY	0	1,407,123	8.00
9.00	00900	NURSING ADMINISTRATION	0	46,571	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	0	355,043	10.00
11.00	01100	PHARMACY	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	12.00
13.00	01300	SOCIAL SERVICE	0	543,528	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	14.00
15.00	01500	OTHER GENERAL SERVICE COST CENTERS	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	SKILLED NURSING FACILITY	0	6,257,634	30.00
31.00	03100	NURSING FACILITY	0	0	31.00
32.00	03200	ICF - MENTALLY RETARDED	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
40.00	04000	RADIOLOGY	0	300	40.00
41.00	04100	LABORATORY	0	20,189	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	28,206	43.00
44.00	04400	PHYSICAL THERAPY	0	379,187	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	544,025	45.00
46.00	04600	SPEECH PATHOLOGY	0	244,303	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	93,858	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	378,744	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	52.00
OUTPATIENT SERVICE COST CENTERS					
60.00	06000	CLINIC	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	61.00
62.00	06200	FOHC	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					
70.00	07000	HOME HEALTH AGENCY COST	0	0	70.00
71.00	07100	AMBULANCE	0	0	71.00
72.00	07200	CORF	0	0	72.00
73.00	07300	CMHC	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	74.00
SPECIAL PURPOSE COST CENTERS					
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	80.00
81.00	08100	INTEREST EXPENSE	0	0	81.00
82.00	08200	UTILIZATION REVIEW	0	0	82.00
83.00	08300	HOSPICE	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	493,605	18,570,631	89.00
NONREIMBURSABLE COST CENTERS					
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	95.00
100.00		TOTAL	493,605	18,570,631	100.00

RECLASSIFICATIONS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet A-6

Date/Time Prepared:
5/2/2016 3:22 pm

		Increases				
		Cost Center	Line #	Salary	Non Salary	
		2.00	3.00	4.00	5.00	
1.00	(1) A - RECLASS NURSING ADMIN					
		NURSING ADMINISTRATION	9.00	46,571	0	1.00
	TOTALS					
100.00		Total Reclassifications (Sum of columns 4 and 5 must equal sum of columns 8 and 9)		46,571	0	100.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
 (2) Transfer to Worksheet A, col. 5, line as appropriate.

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet A-6

Date/Time Prepared:
5/2/2016 3:22 pm

		Decreases				
		Cost Center	Line #	Salary	Non Salary	
	(1) A - RECLASS NURSING ADMIN	6.00	7.00	8.00	9.00	
1.00		SKILLED NURSING FACILITY	30.00	46,571	0	1.00
100.00	TOTALS			46,571	0	100.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, col. 5, line as appropriate.

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet A-7

Date/Time Prepared:
5/2/2016 3:22 pm

Description	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	1,616,526	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	19,711,553	0	0	0	0	3.00
4.00 Building Improvements	240,627	160,475	0	160,475	0	4.00
5.00 Fixed Equipment	0	0	0	0	0	5.00
6.00 Movable Equipment	907,770	6,193	0	6,193	0	6.00
7.00 Subtotal (sum of lines 1-6)	22,476,476	166,668	0	166,668	0	7.00
8.00 Reconciling Items	0	0	0	0	0	8.00
9.00 Total (line 7 minus line 8)	22,476,476	166,668	0	166,668	0	9.00
Description	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	1,616,526	0				1.00
2.00 Land Improvements	0	0				2.00
3.00 Buildings and Fixtures	19,711,553	0				3.00
4.00 Building Improvements	401,102	0				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	913,963	0				6.00
7.00 Subtotal (sum of lines 1-6)	22,643,144	0				7.00
8.00 Reconciling Items	0	0				8.00
9.00 Total (line 7 minus line 8)	22,643,144	0				9.00

ADJUSTMENTS TO EXPENSES

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet A-8

Date/Time Prepared:
5/2/2016 3:22 pm

Description (1)	(2) Basis For Adjustment	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line No.	
			Cost Center			
			1.00	2.00		
1.00 Investment income on restricted funds (chapter 2)	B	-3,656	CAP REL COSTS - BLDGS & FIXTURES		1.00	1.00
2.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	2.00
3.00 Refunds and rebates of expenses (chapter 8)		0			0.00	3.00
4.00 Rental of provider space by suppliers (chapter 8)		0			0.00	4.00
5.00 Telephone services (pay stations excluded) (chapter 21)	B	-8,853	ADMINISTRATIVE & GENERAL		4.00	5.00
6.00 Television and radio service (chapter 21)	B	-11,979	ADMINISTRATIVE & GENERAL		4.00	6.00
7.00 Parking lot (chapter 21)		0			0.00	7.00
8.00 Remuneration applicable to provider-based physician adjustment	A-8-2	0				8.00
9.00 Home office cost (chapter 21)		0			0.00	9.00
10.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	10.00
11.00 Nonallowable costs related to certain Capital expenditures (chapter 24)		0			0.00	11.00
12.00 Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	433,892				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Revenue - Employee meals		0			0.00	14.00
15.00 Cost of meals - Guests		0			0.00	15.00
16.00 Sale of medical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts		0			0.00	18.00
19.00 Vending machines		0			0.00	19.00
20.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	20.00
21.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	21.00
22.00 Utilization review--physicians' compensation (chapter 21)			UTILIZATION REVIEW		82.00	22.00
23.00 Depreciation--buildings and fixtures	A	573,444	CAP REL COSTS - BLDGS & FIXTURES		1.00	23.00
24.00 Depreciation--movable equipment			CAP REL COSTS - MOVABLE EQUIPMENT		2.00	24.00
25.00 Nonallowable Expenses	A	-1,008,865	ADMINISTRATIVE & GENERAL		4.00	25.00
25.01 Nonallowable Travel	A	-151	ADMINISTRATIVE & GENERAL		4.00	25.01
25.02 Reclaim Provider Bed Tax	A	561,405	ADMINISTRATIVE & GENERAL		4.00	25.02
25.03 Nonallowable Salary	A	-41,583	ADMINISTRATIVE & GENERAL		4.00	25.03
25.04 OFFSET MISC REVENUE	B	-49	ADMINISTRATIVE & GENERAL		4.00	25.04
100.00 Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		493,605				100.00

(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.

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

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet A-8-1
Parts 1-11
Date/Time Prepared:
5/2/2016 3:22 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		3.00	EMPLOYEE BENEFITS	Worker's Comp	1.00
2.00		3.00	EMPLOYEE BENEFITS	Unemployment Comp	2.00
3.00		4.00	ADMINISTRATIVE & GENERAL	Welfare Committee	3.00
4.00		4.00	ADMINISTRATIVE & GENERAL	Risk Management	4.00
5.00		4.00	ADMINISTRATIVE & GENERAL	General Management	5.00
6.00		4.00	ADMINISTRATIVE & GENERAL	Auditor	6.00
7.00		4.00	ADMINISTRATIVE & GENERAL	Information Systems	7.00
8.00		4.00	ADMINISTRATIVE & GENERAL	Treasurer	8.00
9.00		4.00	ADMINISTRATIVE & GENERAL	County Board	9.00
9.01		5.00	PLANT OPERATION, MAINT. & REPAIRS	County Buildings	9.01
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.				10.00
		Amount Allowable In Cost	Amount Included in Wkst. A, col. 5	Adjustments (col. 4 minus col. 5)	
		4.00	5.00	6.00	
PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		81,237	0	81,237	1.00
2.00		0	0	0	2.00
3.00		12,326	0	12,326	3.00
4.00		212,214	0	212,214	4.00
5.00		10,530	0	10,530	5.00
6.00		23,744	0	23,744	6.00
7.00		48,002	0	48,002	7.00
8.00		320	0	320	8.00
9.00		45,311	0	45,311	9.00
9.01		208	0	208	9.01
10.00	TOTALS (sum of lines 1-9). Transfer column 6, line 100 to Worksheet A-8, column 3, line 12.	433,892	0	433,892	10.00

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

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet A-8-1
Parts I-III
Date/Time Prepared:
5/2/2016 3:22 pm

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

1.00	G	Rock Island County	100.00	1.00
2.00			0.00	2.00
3.00			0.00	3.00
4.00			0.00	4.00
5.00			0.00	5.00
6.00			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:	County	0.00	100.00

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

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

1.00		Rock Island County	0.00	County Government	1.00
2.00			0.00		2.00
3.00			0.00		3.00
4.00			0.00		4.00
5.00			0.00		5.00
6.00			0.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:		0.00		100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B
Part I
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	1,215,575	1,215,575			1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT	0		0		2.00
3.00 00300	EMPLOYEE BENEFITS	3,255,566	0	0	3,255,566	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	2,378,706	142,048	0	130,293	2,651,047
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	727,308	60,480	0	86,015	873,803
6.00 00600	LAUNDRY & LINEN SERVICE	317,481	27,413	0	116,325	461,219
7.00 00700	HOUSEKEEPING	377,284	9,412	0	118,108	504,804
8.00 00800	DIETARY	1,407,123	74,786	0	302,814	1,784,723
9.00 00900	NURSING ADMINISTRATION	46,571	22,620	0	34,870	104,061
10.00 01000	CENTRAL SERVICES & SUPPLY	355,043	14,244	0	0	369,287
11.00 01100	PHARMACY	0	0	0	0	0
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
13.00 01300	SOCIAL SERVICE	543,528	3,188	0	211,875	758,591
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0
15.00 01500	OTHER GENERAL SERVICE COST CENTERS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	6,257,634	823,473	0	2,195,577	9,276,684
31.00 03100	NURSING FACILITY	0	0	0	0	0
32.00 03200	ICF - MENTALLY RETARDED	0	0	0	0	0
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	300	0	0	0	300
41.00 04100	LABORATORY	20,189	0	0	0	20,189
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0
43.00 04300	OXYGEN (INHALATION) THERAPY	28,206	0	0	0	28,206
44.00 04400	PHYSICAL THERAPY	379,187	11,087	0	0	390,274
45.00 04500	OCCUPATIONAL THERAPY	544,025	15,909	0	59,689	619,623
46.00 04600	SPEECH PATHOLOGY	244,303	7,148	0	0	251,451
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	93,858	3,767	0	0	97,625
49.00 04900	DRUGS CHARGED TO PATIENTS	378,744	0	0	0	378,744
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0
51.00 05100	SUPPORT SURFACES	0	0	0	0	0
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0
62.00 06200	FOHC	0	0	0	0	0
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0
71.00 07100	AMBULANCE	0	0	0	0	0
72.00 07200	CORF	0	0	0	0	0
73.00 07300	CMHC	0	0	0	0	0
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	0
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0
89.00	SUBTOTALS (sum of lines 1-84)	18,570,631	1,215,575	0	3,255,566	18,570,631
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0
93.00 09300	NONPAID WORKERS	0	0	0	0	0
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0
95.00 09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
98.00	Cross Foot Adjustments	0	0	0	0	0
99.00	Negative Cost Centers	0	0	0	0	0
100.00	TOTAL	18,570,631	1,215,575	0	3,255,566	18,570,631

COST ALLOCATION - GENERAL SERVICE COSTS		Provider No. : 145269		Period: From 12/01/2014 To 11/30/2015		Worksheet B Part I Date/Time Prepared: 5/2/2016 3:22 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES					1.00	
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00	
3.00	00300	EMPLOYEE BENEFITS					3.00	
4.00	00400	ADMINISTRATIVE & GENERAL	2,651,047				4.00	
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS	145,512	1,019,315			5.00	
6.00	00600	LAUNDRY & LINEN SERVICE	76,805	27,582	565,606		6.00	
7.00	00700	HOUSEKEEPING	84,063	9,470	0	598,337	7.00	
8.00	00800	DIETARY	297,205	75,248	0	45,837	2,203,013	8.00
9.00	00900	NURSING ADMINISTRATION	17,329	22,760	0	13,864	0	9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	61,496	14,333	0	8,731	0	10.00
11.00	01100	PHARMACY	0	0	0	0	0	11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00	01300	SOCIAL SERVICE	126,326	3,208	0	1,954	0	13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	OTHER GENERAL SERVICE COST CENTERS	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	1,544,826	828,569	565,606	504,715	2,203,013	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF - MENTALLY RETARDED	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	50	0	0	0	0	40.00
41.00	04100	LABORATORY	3,362	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	4,697	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	64,991	11,155	0	6,795	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	103,184	16,008	0	9,751	0	45.00
46.00	04600	SPEECH PATHOLOGY	41,873	7,192	0	4,381	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,257	3,790	0	2,309	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	63,071	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	2,651,047	1,019,315	565,606	598,337	2,203,013	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	0	0	99.00
100.00		TOTAL	2,651,047	1,019,315	565,606	598,337	2,203,013	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B
Part I
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	158,014					9.00
10.00	01000		453,847				10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300					890,079	13.00
14.00	01400						14.00
15.00	01500						15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	158,014	453,847			890,079	30.00
31.00	03100						31.00
32.00	03200						32.00
33.00	03300						33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000						40.00
41.00	04100						41.00
42.00	04200						42.00
43.00	04300						43.00
44.00	04400						44.00
45.00	04500						45.00
46.00	04600						46.00
47.00	04700						47.00
48.00	04800						48.00
49.00	04900						49.00
50.00	05000						50.00
51.00	05100						51.00
52.00	05200						52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000						60.00
61.00	06100						61.00
62.00	06200						62.00
63.00	06300						63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000						70.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300						73.00
74.00	07400						74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300						83.00
84.00	08400						84.00
89.00		158,014	453,847			890,079	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000						90.00
91.00	09100						91.00
92.00	09200						92.00
93.00	09300						93.00
94.00	09400						94.00
95.00	09500						95.00
98.00							98.00
99.00							99.00
100.00		158,014	453,847			890,079	100.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B
Part I
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST CENTERS	Subtotal	Post Stepdown Adjustments	Total	
		14.00				
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES				1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT				2.00
3.00	00300	EMPLOYEE BENEFITS				3.00
4.00	00400	ADMINISTRATIVE & GENERAL				4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS				5.00
6.00	00600	LAUNDRY & LINEN SERVICE				6.00
7.00	00700	HOUSEKEEPING				7.00
8.00	00800	DIETARY				8.00
9.00	00900	NURSING ADMINISTRATION				9.00
10.00	01000	CENTRAL SERVICES & SUPPLY				10.00
11.00	01100	PHARMACY				11.00
12.00	01200	MEDICAL RECORDS & LIBRARY				12.00
13.00	01300	SOCIAL SERVICE				13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0			14.00
15.00	01500	OTHER GENERAL SERVICE COST CENTERS	0	0		15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	SKILLED NURSING FACILITY	0	0	16,425,353	30.00
31.00	03100	NURSING FACILITY	0	0	0	31.00
32.00	03200	ICF - MENTALLY RETARDED	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00	04000	RADIOLOGY	0	0	350	40.00
41.00	04100	LABORATORY	0	0	23,551	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	32,903	43.00
44.00	04400	PHYSICAL THERAPY	0	0	473,215	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	748,566	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	304,897	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	119,981	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	441,815	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	CLINIC	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	61.00
62.00	06200	FOHC	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	71.00
72.00	07200	CORF	0	0	0	72.00
73.00	07300	CMHC	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES				80.00
81.00	08100	INTEREST EXPENSE				81.00
82.00	08200	UTILIZATION REVIEW				82.00
83.00	08300	HOSPICE	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	0	0	18,570,631	89.00
NONREIMBURSABLE COST CENTERS						
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	95.00
98.00		Cross Foot Adjustments	0	0	0	98.00
99.00		Negative Cost Centers	0	0	0	99.00
100.00		TOTAL	0	0	18,570,631	100.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B
Part II
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDGS & FIXTURES	MOVABLE EQUIPMENT			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	0	0	3.00
4.00 00400	ADMINISTRATIVE & GENERAL	0	142,048	0	142,048	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	0	60,480	0	60,480	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	0	27,413	0	27,413	6.00
7.00 00700	HOUSEKEEPING	0	9,412	0	9,412	7.00
8.00 00800	DIETARY	0	74,786	0	74,786	8.00
9.00 00900	NURSING ADMINISTRATION	0	22,620	0	22,620	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	0	14,244	0	14,244	10.00
11.00 01100	PHARMACY	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	0	3,188	0	3,188	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	14.00
15.00 01500	OTHER GENERAL SERVICE COST CENTERS	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	823,473	0	823,473	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF - MENTALLY RETARDED	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	0	0	40.00
41.00 04100	LABORATORY	0	0	0	0	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 04400	PHYSICAL THERAPY	0	11,087	0	11,087	44.00
45.00 04500	OCCUPATIONAL THERAPY	0	15,909	0	15,909	45.00
46.00 04600	SPEECH PATHOLOGY	0	7,148	0	7,148	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,767	0	3,767	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	72.00
73.00 07300	CMHC	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	1,215,575	0	1,215,575	89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	95.00
98.00	Cross Foot Adjustments				0	98.00
99.00	Negative Cost Centers		0	0	0	99.00
100.00	TOTAL	0	1,215,575	0	1,215,575	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 145269		Period: From 12/01/2014 To 11/30/2015		Worksheet B Part II Date/Time Prepared: 5/2/2016 3:22 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400	142,048					4.00
5.00	00500	7,797	68,277				5.00
6.00	00600	4,115	1,848	33,376			6.00
7.00	00700	4,504	634	0	14,550		7.00
8.00	00800	15,925	5,040	0	1,115	96,866	8.00
9.00	00900	929	1,525	0	337	0	9.00
10.00	01000	3,295	960	0	212	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	6,769	215	0	48	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	82,773	55,500	33,376	12,273	96,866	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	3	0	0	0	0	40.00
41.00	04100	180	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	252	0	0	0	0	43.00
44.00	04400	3,482	747	0	165	0	44.00
45.00	04500	5,529	1,072	0	237	0	45.00
46.00	04600	2,244	482	0	107	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	871	254	0	56	0	48.00
49.00	04900	3,380	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
89.00		142,048	68,277	33,376	14,550	96,866	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00		0	0	0	0	0	99.00
100.00		142,048	68,277	33,376	14,550	96,866	100.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet B Part II Date/Time Prepared: 5/2/2016 3:22 pm		
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
		9.00	10.00	11.00	12.00	13.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
3.00	00300					3.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900	25,411				9.00
10.00	01000	0	18,711			10.00
11.00	01100	0	0	0		11.00
12.00	01200	0	0	0	0	12.00
13.00	01300	0	0	0	0	10,220
14.00	01400	0	0	0	0	0
15.00	01500	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	25,411	18,711	0	0	10,220
31.00	03100	0	0	0	0	0
32.00	03200	0	0	0	0	0
33.00	03300	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
40.00	04000	0	0	0	0	0
41.00	04100	0	0	0	0	0
42.00	04200	0	0	0	0	0
43.00	04300	0	0	0	0	0
44.00	04400	0	0	0	0	0
45.00	04500	0	0	0	0	0
46.00	04600	0	0	0	0	0
47.00	04700	0	0	0	0	0
48.00	04800	0	0	0	0	0
49.00	04900	0	0	0	0	0
50.00	05000	0	0	0	0	0
51.00	05100	0	0	0	0	0
52.00	05200	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
60.00	06000	0	0	0	0	0
61.00	06100	0	0	0	0	0
62.00	06200	0	0	0	0	0
63.00	06300	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
70.00	07000	0	0	0	0	0
71.00	07100	0	0	0	0	0
72.00	07200	0	0	0	0	0
73.00	07300	0	0	0	0	0
74.00	07400	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
80.00	08000					80.00
81.00	08100					81.00
82.00	08200					82.00
83.00	08300	0	0	0	0	0
84.00	08400	0	0	0	0	0
89.00		25,411	18,711	0	0	10,220
NONREIMBURSABLE COST CENTERS						
90.00	09000	0	0	0	0	0
91.00	09100	0	0	0	0	0
92.00	09200	0	0	0	0	0
93.00	09300	0	0	0	0	0
94.00	09400	0	0	0	0	0
95.00	09500	0	0	0	0	0
98.00		0	0	0	0	0
99.00		0	0	0	0	0
100.00	TOTAL	25,411	18,711	0	0	10,220

ALLOCATION OF CAPITAL RELATED COSTS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B
Part II
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description	NURSING AND ALLIED HEALTH EDUCATION	OTHER GENERAL SERVICE COST CENTERS	Subtotal	Post Step-Down Adjustments	Total	
		14.00 15.00				
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 00300	EMPLOYEE BENEFITS					3.00
4.00 00400	ADMINISTRATIVE & GENERAL					4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 00600	LAUNDRY & LINEN SERVICE					6.00
7.00 00700	HOUSEKEEPING					7.00
8.00 00800	DIETARY					8.00
9.00 00900	NURSING ADMINISTRATION					9.00
10.00 01000	CENTRAL SERVICES & SUPPLY					10.00
11.00 01100	PHARMACY					11.00
12.00 01200	MEDICAL RECORDS & LIBRARY					12.00
13.00 01300	SOCIAL SERVICE					13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0				14.00
15.00 01500	OTHER GENERAL SERVICE COST CENTERS	0	0			15.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	SKILLED NURSING FACILITY	0	0	1,158,603	0	1,158,603
31.00 03100	NURSING FACILITY	0	0	0	0	31.00
32.00 03200	ICF - MENTALLY RETARDED	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
40.00 04000	RADIOLOGY	0	0	3	0	3 40.00
41.00 04100	LABORATORY	0	0	180	0	180 41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0 42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	252	0	252 43.00
44.00 04400	PHYSICAL THERAPY	0	0	15,481	0	15,481 44.00
45.00 04500	OCCUPATIONAL THERAPY	0	0	22,747	0	22,747 45.00
46.00 04600	SPEECH PATHOLOGY	0	0	9,981	0	9,981 46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0 47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,948	0	4,948 48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	3,380	0	3,380 49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0 50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0 51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 52.00
OUTPATIENT SERVICE COST CENTERS						
60.00 06000	CLINIC	0	0	0	0	0 60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0 61.00
62.00 06200	FOHC	0	0	0	0	0 62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 63.00
OTHER REIMBURSABLE COST CENTERS						
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0 70.00
71.00 07100	AMBULANCE	0	0	0	0	0 71.00
72.00 07200	CORF	0	0	0	0	0 72.00
73.00 07300	CMHC	0	0	0	0	0 73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0 74.00
SPECIAL PURPOSE COST CENTERS						
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 08100	INTEREST EXPENSE					81.00
82.00 08200	UTILIZATION REVIEW					82.00
83.00 08300	HOSPICE	0	0	0	0	0 83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0 84.00
89.00	SUBTOTALS (sum of lines 1-84)	0	0	1,215,575	0	1,215,575 89.00
NONREIMBURSABLE COST CENTERS						
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0 90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0 91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0 92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0 93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0 94.00
95.00 09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 95.00
98.00	Cross Foot Adjustments	0	0	0	0	0 98.00
99.00	Negative Cost Centers	0	0	0	0	0 99.00
100.00	TOTAL	0	0	1,215,575	0	1,215,575 100.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B-1
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS - BLDGS & FIXTURES	119,728					1.00
2.00 00200	CAP REL COSTS - MOVABLE EQUIPMENT		0				2.00
3.00 00300	EMPLOYEE BENEFITS	0	0	8,230,258			3.00
4.00 00400	ADMINISTRATIVE & GENERAL	13,991	0	329,387	-2,651,047	15,919,584	4.00
5.00 00500	PLANT OPERATION, MAINT. & REPAIRS	5,957	0	217,450	0	873,803	5.00
6.00 00600	LAUNDRY & LINEN SERVICE	2,700	0	294,076	0	461,219	6.00
7.00 00700	HOUSEKEEPING	927	0	298,583	0	504,804	7.00
8.00 00800	DIETARY	7,366	0	765,530	0	1,784,723	8.00
9.00 00900	NURSING ADMINISTRATION	2,228	0	88,154	0	104,061	9.00
10.00 01000	CENTRAL SERVICES & SUPPLY	1,403	0	0	0	369,287	10.00
11.00 01100	PHARMACY	0	0	0	0	0	11.00
12.00 01200	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	12.00
13.00 01300	SOCIAL SERVICE	314	0	535,631	0	758,591	13.00
14.00 01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00 01500	OTHER GENERAL SERVICE COST CENTERS	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	SKILLED NURSING FACILITY	81,108	0	5,550,549	0	9,276,684	30.00
31.00 03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00 03200	ICF - MENTALLY RETARDED	0	0	0	0	0	32.00
33.00 03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00 04000	RADIOLOGY	0	0	0	0	300	40.00
41.00 04100	LABORATORY	0	0	0	0	20,189	41.00
42.00 04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00 04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	28,206	43.00
44.00 04400	PHYSICAL THERAPY	1,092	0	0	0	390,274	44.00
45.00 04500	OCCUPATIONAL THERAPY	1,567	0	150,898	0	619,623	45.00
46.00 04600	SPEECH PATHOLOGY	704	0	0	0	251,451	46.00
47.00 04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00 04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	371	0	0	0	97,625	48.00
49.00 04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	378,744	49.00
50.00 05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00 05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00 05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00 06000	CLINIC	0	0	0	0	0	60.00
61.00 06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00 06200	FOHC	0	0	0	0	0	62.00
63.00 06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00 07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00 07100	AMBULANCE	0	0	0	0	0	71.00
72.00 07200	CORF	0	0	0	0	0	72.00
73.00 07300	CMHC	0	0	0	0	0	73.00
74.00 07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00 08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00 08100	INTEREST EXPENSE						81.00
82.00 08200	UTILIZATION REVIEW						82.00
83.00 08300	HOSPICE	0	0	0	0	0	83.00
84.00 08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00	SUBTOTALS (sum of lines 1-84)	119,728	0	8,230,258	-2,651,047	15,919,584	89.00
NONREIMBURSABLE COST CENTERS							
90.00 09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00 09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00 09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00 09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00 09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00 09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments						98.00
99.00	Negative Cost Centers						99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1,215,575	0	3,255,566		2,651,047	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	10.152805	0.000000	0.395561		0.166527	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		142,048	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.008923	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B-1

Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description		PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
3.00	00300						3.00
4.00	00400						4.00
5.00	00500	99,780					5.00
6.00	00600	2,700	77,310				6.00
7.00	00700	927	0	96,153			7.00
8.00	00800	7,366	0	7,366	231,930		8.00
9.00	00900	2,228	0	2,228	0	350,945	9.00
10.00	01000	1,403	0	1,403	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	314	0	314	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	81,108	77,310	81,108	231,930	350,945	30.00
31.00	03100	0	0	0	0	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,092	0	1,092	0	0	44.00
45.00	04500	1,567	0	1,567	0	0	45.00
46.00	04600	704	0	704	0	0	46.00
47.00	04700	0	0	0	0	0	47.00
48.00	04800	371	0	371	0	0	48.00
49.00	04900	0	0	0	0	0	49.00
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS							
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS							
80.00	08000						80.00
81.00	08100						81.00
82.00	08200						82.00
83.00	08300	0	0	0	0	0	83.00
84.00	08400	0	0	0	0	0	84.00
89.00		99,780	77,310	96,153	231,930	350,945	89.00
NONREIMBURSABLE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	09300	0	0	0	0	0	93.00
94.00	09400	0	0	0	0	0	94.00
95.00	09500	0	0	0	0	0	95.00
98.00							98.00
99.00							99.00
102.00		1,019,315	565,606	598,337	2,203,013	158,014	102.00
103.00		10.215624	7.316078	6.222760	9.498612	0.450253	103.00
104.00		68,277	33,376	14,550	96,866	25,411	104.00
105.00		0.684275	0.431716	0.151321	0.417652	0.072407	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B-1
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY (TOTAL PATIENT DAYS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES						1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT						2.00
3.00	00300	EMPLOYEE BENEFITS						3.00
4.00	00400	ADMINISTRATIVE & GENERAL						4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS						5.00
6.00	00600	LAUNDRY & LINEN SERVICE						6.00
7.00	00700	HOUSEKEEPING						7.00
8.00	00800	DIETARY						8.00
9.00	00900	NURSING ADMINISTRATION						9.00
10.00	01000	CENTRAL SERVICES & SUPPLY	77,310					10.00
11.00	01100	PHARMACY	0	0				11.00
12.00	01200	MEDICAL RECORDS & LIBRARY	0	0	0			12.00
13.00	01300	SOCIAL SERVICE	0	0	0	77,310		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	14.00
15.00	01500	OTHER GENERAL SERVICE COST CENTERS	0	0	0	0	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	SKILLED NURSING FACILITY	77,310	0	0	77,310	0	30.00
31.00	03100	NURSING FACILITY	0	0	0	0	0	31.00
32.00	03200	ICF - MENTALLY RETARDED	0	0	0	0	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0	0	0	0	0	40.00
41.00	04100	LABORATORY	0	0	0	0	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	43.00
44.00	04400	PHYSICAL THERAPY	0	0	0	0	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	0	0	0	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	0	0	0	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	0	0	0	0	61.00
62.00	06200	FOHC	0	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS								
70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	70.00
71.00	07100	AMBULANCE	0	0	0	0	0	71.00
72.00	07200	CORF	0	0	0	0	0	72.00
73.00	07300	CMHC	0	0	0	0	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS								
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES						80.00
81.00	08100	INTEREST EXPENSE						81.00
82.00	08200	UTILIZATION REVIEW						82.00
83.00	08300	HOSPICE	0	0	0	0	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	77,310	0	0	77,310	0	89.00
NONREIMBURSABLE COST CENTERS								
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	0	0	0	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	95.00
98.00		Cross Foot Adjustments						98.00
99.00		Negative Cost Centers						99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	453,847	0	0	890,079	0	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	5.870482	0.000000	0.000000	11.513116	0.000000	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	18,711	0	0	10,220	0	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.242026	0.000000	0.000000	0.132195	0.000000	105.00

COST ALLOCATION - STATISTICAL BASIS

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet B-1
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description		OTHER GENERAL SERVICE		
		COST CENTERS (ASSIGNED TIME)		
		15.00		
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS - BLDGS & FIXTURES		1.00
2.00	00200	CAP REL COSTS - MOVABLE EQUIPMENT		2.00
3.00	00300	EMPLOYEE BENEFITS		3.00
4.00	00400	ADMINISTRATIVE & GENERAL		4.00
5.00	00500	PLANT OPERATION, MAINT. & REPAIRS		5.00
6.00	00600	LAUNDRY & LINEN SERVICE		6.00
7.00	00700	HOUSEKEEPING		7.00
8.00	00800	DIETARY		8.00
9.00	00900	NURSING ADMINISTRATION		9.00
10.00	01000	CENTRAL SERVICES & SUPPLY		10.00
11.00	01100	PHARMACY		11.00
12.00	01200	MEDICAL RECORDS & LIBRARY		12.00
13.00	01300	SOCIAL SERVICE		13.00
14.00	01400	NURSING AND ALLIED HEALTH EDUCATION		14.00
15.00	01500	OTHER GENERAL SERVICE COST CENTERS	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	SKILLED NURSING FACILITY	0	30.00
31.00	03100	NURSING FACILITY	0	31.00
32.00	03200	ICF - MENTALLY RETARDED	0	32.00
33.00	03300	OTHER LONG TERM CARE	0	33.00
ANCILLARY SERVICE COST CENTERS				
40.00	04000	RADIOLOGY	0	40.00
41.00	04100	LABORATORY	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	0	43.00
44.00	04400	PHYSICAL THERAPY	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	0	45.00
46.00	04600	SPEECH PATHOLOGY	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	50.00
51.00	05100	SUPPORT SURFACES	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	52.00
OUTPATIENT SERVICE COST CENTERS				
60.00	06000	CLINIC	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0	61.00
62.00	06200	FOHC	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0	63.00
OTHER REIMBURSABLE COST CENTERS				
70.00	07000	HOME HEALTH AGENCY COST	0	70.00
71.00	07100	AMBULANCE	0	71.00
72.00	07200	CORF	0	72.00
73.00	07300	CMHC	0	73.00
74.00	07400	OTHER REIMBURSABLE COST	0	74.00
SPECIAL PURPOSE COST CENTERS				
80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		80.00
81.00	08100	INTEREST EXPENSE		81.00
82.00	08200	UTILIZATION REVIEW		82.00
83.00	08300	HOSPICE	0	83.00
84.00	08400	OTHER SPECIAL PURPOSE COST CENTERS	0	84.00
89.00		SUBTOTALS (sum of lines 1-84)	0	89.00
NONREIMBURSABLE COST CENTERS				
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	92.00
93.00	09300	NONPAID WORKERS	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	94.00
95.00	09500	OTHER NONREIMBURSABLE COST CENTERS	0	95.00
98.00		Cross Foot Adjustments		98.00
99.00		Negative Cost Centers		99.00
102.00		Cost to be allocated (per Wkst. B, Part I)	0	102.00
103.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	103.00
104.00		Cost to be allocated (per Wkst. B, Part II)	0	104.00
105.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	105.00

RATIO OF COST TO CHARGES FOR ANCI LLARY AND OUTPATIENT COST CENTERS

Provi der No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet C
Date/Time Prepared:
5/2/2016 3: 22 pm

Cost Center Description			Total (from	Total Charges	Ratio (col . 1	
			Wkst. B, Pt 1, col . 18)		di vi ded by col . 2	
			1. 00	2. 00	3. 00	
ANCI LLARY SERVICE COST CENTERS						
40. 00	04000	RADI OLOGY	350	1, 895	0. 184697	40. 00
41. 00	04100	LABORATORY	23, 551	9, 541	2. 468400	41. 00
42. 00	04200	INTRAVENOUS THERAPY	0	0	0. 000000	42. 00
43. 00	04300	OXYGEN (I NHALATI ON) THERAPY	32, 903	10, 653	3. 088614	43. 00
44. 00	04400	PHYSI CAL THERAPY	473, 215	576, 984	0. 820153	44. 00
45. 00	04500	OCCUPATI ONAL THERAPY	748, 566	496, 381	1. 508047	45. 00
46. 00	04600	SPEECH PATHOLOGY	304, 897	382, 920	0. 796242	46. 00
47. 00	04700	ELECTROCARDI OLOGY	0	0	0. 000000	47. 00
48. 00	04800	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	119, 981	13, 382	8. 965850	48. 00
49. 00	04900	DRUGS CHARGED TO PATI ENTS	441, 815	281, 131	1. 571563	49. 00
50. 00	05000	DENTAL CARE - TI TLE XI X ONLY	0	0	0. 000000	50. 00
51. 00	05100	SUPPORT SURFACES	0	0	0. 000000	51. 00
52. 00	05200	OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0. 000000	52. 00
OUTPATI ENT SERVICE COST CENTERS						
60. 00	06000	CLI NI C	0	0	0. 000000	60. 00
61. 00	06100	RURAL HEALTH CLI NI C	0	0	0. 000000	61. 00
62. 00	06200	FOHC	0	0	0. 000000	62. 00
63. 00	06300	OTHER OUTPATI ENT SERVI CE COST CENTER	0	0	0. 000000	63. 00
71. 00	07100	AMBULANCE	0	0	0. 000000	71. 00
100. 00		Total	2, 145, 278	1, 772, 887		100. 00

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet D Part I Date/Time Prepared: 5/2/2016 3:22 pm
		Title XVIII (1)	Skilled Nursing Facility	PPS

Cost Center Description	Ratio of Cost to Charges (Fr. Wkst. C Column 3)	Health Care Program Charges		Health Care Program Cost				
		Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)			
		2.00	3.00	4.00	5.00			
PART I - CALCULATION OF ANCILLARY AND OUTPATIENT COST								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	0.184697	1,895	0	350	0	40.00
41.00	04100	LABORATORY	2.468400	9,541	0	23,551	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0.000000	0	0	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	3.088614	10,653	0	32,903	0	43.00
44.00	04400	PHYSICAL THERAPY	0.820153	426,352	0	349,674	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	1.508047	495,302	0	746,939	0	45.00
46.00	04600	SPEECH PATHOLOGY	0.796242	382,920	0	304,897	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	8.965850	120	0	1,076	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	1.571563	281,131	0	441,815	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0.000000	0	0	0	0	50.00
51.00	05100	SUPPORT SURFACES	0.000000	0	0	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS								
60.00	06000	CLINIC	0.000000	0	0	0	0	60.00
61.00	06100	RURAL HEALTH CLINIC	0.000000	0	0	0	0	61.00
62.00	06200	FOHC	0.000000	0	0	0	0	62.00
63.00	06300	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	63.00
71.00	07100	AMBULANCE (2)	0.000000	0	0	0	0	71.00
100.00		Total (Sum of lines 40 - 71)		1,607,914	0	1,901,205	0	100.00

(1) For title V and XIX use columns 1, 2, and 4 only.

(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS		Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet D Parts II-III Date/Time Prepared: 5/2/2016 3:22 pm				
		Title XVIII	Skilled Nursing Facility	PPS				
Cost Center Description					1.00			
PART II - APPORTIONMENT OF VACCINE COST								
1.00		Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)		1.571563	1.00			
2.00		Program vaccine charges (From your records, or the PS&R)		0	2.00			
3.00		Program costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer this amount to Worksheet E, Part I, line 18)		0	3.00			
Cost Center Description		Total Cost (From Wkst. B, Part I, Col. 18)	Nursing & Allied Health (From Wkst. B, Part I, Col. 14)	Ratio of Nursing & Allied Health Costs to Total Costs - Part A (Col. 2 / Col. 1)	Program Part A Cost (From Wkst. D Part I, Col. 4)	Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4)		
		1.00	2.00	3.00	4.00	5.00		
PART III - CALCULATION OF PASS THROUGH COSTS FOR NURSING & ALLIED HEALTH								
ANCILLARY SERVICE COST CENTERS								
40.00	04000	RADIOLOGY	350	0	0.000000	350	0	40.00
41.00	04100	LABORATORY	23,551	0	0.000000	23,551	0	41.00
42.00	04200	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	04300	OXYGEN (INHALATION) THERAPY	32,903	0	0.000000	32,903	0	43.00
44.00	04400	PHYSICAL THERAPY	473,215	0	0.000000	349,674	0	44.00
45.00	04500	OCCUPATIONAL THERAPY	748,566	0	0.000000	746,939	0	45.00
46.00	04600	SPEECH PATHOLOGY	304,897	0	0.000000	304,897	0	46.00
47.00	04700	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	119,981	0	0.000000	1,076	0	48.00
49.00	04900	DRUGS CHARGED TO PATIENTS	441,815	0	0.000000	441,815	0	49.00
50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	05100	SUPPORT SURFACES	0	0	0.000000	0	0	51.00
52.00	05200	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	52.00
100.00		Total (Sum of lines 40 - 52)	2,145,278	0		1,901,205	0	100.00

COMPUTATION OF INPATIENT ROUTINE COSTS	Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet D-1 Parts I-II Date/Time Prepared: 5/2/2016 3:22 pm
	Title XVIII	Skilled Nursing Facility	PPS

			1.00	
PART I CALCULATION OF INPATIENT ROUTINE COSTS				
INPATIENT DAYS				
1.00	Inpatient days including private room days		77,310	1.00
2.00	Private room days		0	2.00
3.00	Inpatient days including private room days applicable to the Program		6,238	3.00
4.00	Medically necessary private room days applicable to the Program		0	4.00
5.00	Total general inpatient routine service cost		16,425,353	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
6.00	General inpatient routine service charges		13,583,230	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)		1.209238	7.00
8.00	Enter private room charges from your records		0	8.00
9.00	Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)		0.00	9.00
10.00	Enter semi-private room charges from your records		0	10.00
11.00	Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)		0.00	11.00
12.00	Average per diem private room charge differential (Line 9 minus line 11)		0.00	12.00
13.00	Average per diem private room cost differential (Line 7 times line 12)		0.00	13.00
14.00	Private room cost differential adjustment (Line 2 times line 13)		0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)		16,425,353	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS				
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)		212.46	16.00
17.00	Program routine service cost (Line 3 times line 16)		1,325,325	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)		0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)		1,325,325	19.00
20.00	Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, - line 30 for SNF; line 31 for NF, or line 32 for ICF/MR)		1,158,603	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)		14.99	21.00
22.00	Program capital related cost (Line 3 times line 21)		93,508	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)		1,231,817	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)		0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)		1,231,817	25.00
26.00	Enter the per diem limitation (1)			26.00
27.00	Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)			27.00
28.00	Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)			28.00

(1) Lines 26 and 27 are not applicable for title XVIII, but may be used for title V and or title XIX

			1.00	
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH				
1.00	Total SNF inpatient days		77,310	1.00
2.00	Program inpatient days (see instructions)		6,238	2.00
3.00	Total nursing & allied health costs. (see instructions)(Do not complete for titles V or XIX)		0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)		0.080688	4.00
5.00	Program nursing & allied health costs for pass-through. (line 3 times line 4)		0	5.00

CALCULATION OF REIMBURSEMENT SETTLEMENT TITLE XVIII		Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet E Part I Date/Time Prepared: 5/2/2016 3:22 pm
		Title XVIII	Skilled Nursing Facility	PPS

		1.00	
PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT			
1.00	Inpatient PPS amount (See Instructions)	3,151,145	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)	0	2.00
3.00	Subtotal (Sum of lines 1 and 2)	3,151,145	3.00
4.00	Primary payor amounts	0	4.00
5.00	Coinsurance	571,037	5.00
6.00	Reimbursable bad debts (From your records)	0	6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (See instructions)	0	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	0	8.00
9.00	Recovery of bad debts - for statistical records only	0	9.00
10.00	Utilization review	0	10.00
11.00	Subtotal (See instructions)	2,580,108	11.00
12.00	Interim payments (See instructions)	2,555,866	12.00
13.00	Tentative adjustment	0	13.00
14.00	OTHER adjustment (See instructions)	0	14.00
14.99	Sequestration amount (see instructions)	51,602	14.99
15.00	Balance due provider/program (see Instructions)	-27,360	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	0	16.00
PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY			
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	0	18.00
19.00	Total reasonable costs (Sum of lines 17 and 18)	0	19.00
20.00	Medicare Part B ancillary charges (See instructions)	0	20.00
21.00	Cost of covered services (Lesser of line 19 or line 20)	0	21.00
22.00	Primary payor amounts	0	22.00
23.00	Coinsurance and deductibles	0	23.00
24.00	Reimbursable bad debts (From your records)	0	24.00
24.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	24.01
24.02	Adjusted reimbursable bad debts (see instructions)	0	24.02
25.00	Subtotal (Sum of lines 21 and 24, minus lines 22 and 23)	0	25.00
26.00	Interim payments (See instructions)	0	26.00
27.00	Tentative adjustment	0	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
28.99	Sequestration amount (see instructions)	0	28.99
29.00	Balance due provider/program (see instructions)	0	29.00
30.00	Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2	0	30.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider No. : 145269	Period: From 12/01/2014 To 11/30/2015	Worksheet E-1 Date/Time Prepared: 5/2/2016 3:22 pm		
		Title XVIII	Skilled Nursing Facility	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	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, enter zero		2,555,866		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A, and line 26 for Part B)		2,555,866		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	PROGRAM TO PROVIDER		0		0	6.01
6.02	PROVIDER TO PROGRAM		27,360		0	6.02
7.00	Total Medicare program liability (see instructions)		2,528,506		0	7.00
			Contractor Name		Contractor Number	
			1.00		2.00	
8.00	Name of Contractor					8.00

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet G

Date/Time Prepared:
5/2/2016 3:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
CURRENT ASSETS						
1.00	Cash on hand and in banks	44,078	0	0	0	1.00
2.00	Temporary investments	233,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,012,843	0	0	0	4.00
5.00	Other receivables	1,173,513	0	0	0	5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	1,480	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	5,464,914	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Less: Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Less Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Less: Accumulated Amortization	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Less: Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Less: Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Less: Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment - Depreciable	0	0	0	0	25.00
26.00	Minor equipment nondepreciable	0	0	0	0	26.00
27.00	Other fixed assets	0	0	0	0	27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	0	0	0	0	28.00
OTHER ASSETS						
29.00	Investments	0	0	0	0	29.00
30.00	Deposits on leases	0	0	0	0	30.00
31.00	Due from owners/officers	0	0	0	0	31.00
32.00	Other assets	0	0	0	0	32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	0	0	0	0	33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	5,464,914	0	0	0	34.00
Liabilities and Fund Balances						
CURRENT LIABILITIES						
35.00	Accounts payable	768,168	0	0	0	35.00
36.00	Salaries, wages, and fees payable	229,887	0	0	0	36.00
37.00	Payroll taxes payable	0	0	0	0	37.00
38.00	Notes & loans payable (Short term)	0	0	0	0	38.00
39.00	Deferred income	1,079,438	0	0	0	39.00
40.00	Accelerated payments	0	0	0	0	40.00
41.00	Due to other funds	753,482	0	0	0	41.00
42.00	Other current liabilities	2,843,741	0	0	0	42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	5,674,716	0	0	0	43.00
LONG TERM LIABILITIES						
44.00	Mortgage payable	0	0	0	0	44.00
45.00	Notes payable	0	0	0	0	45.00
46.00	Unsecured loans	0	0	0	0	46.00
47.00	Loans from owners:	0	0	0	0	47.00
48.00	Other long term liabilities	0	0	0	0	48.00
49.00	OTHER (SPECIFY)	0	0	0	0	49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49)	0	0	0	0	50.00
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	5,674,716	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-209,802	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-209,802	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	5,464,914	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet G-1

Date/Time Prepared:
5/2/2016 3:22 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		503,717		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 31)		-713,518			2.00
3.00	Total (sum of line 1 and line 2)		-209,801		0	3.00
4.00	Additions (credit adjustments)					4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-209,801		0	11.00
12.00	Deductions (debit adjustments)					12.00
13.00	Rounding	1		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		1		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-209,802		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 31)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments)					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 5 - 9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments)					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 13 - 17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet G-2
Parts I-III
Date/Time Prepared:
5/2/2016 3:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Care Services					
1.00	SKILLED NURSING FACILITY	13,583,230		13,583,230	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/MR	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	13,583,230		13,583,230	5.00
All Other Care Services					
6.00	ANCILLARY SERVICES	164,973	0	164,973	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
11.10	CORF		0	0	11.10
12.00	SNF Based HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	13,748,203	0	13,748,203	14.00
Cost Center Description			1.00	2.00	
PART II - OPERATING EXPENSES					
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			18,077,026	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
15.00	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			18,077,026	15.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider No. : 145269

Period:
From 12/01/2014
To 11/30/2015

Worksheet G-3

Date/Time Prepared:
5/2/2016 3:22 pm

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	13,748,203	1.00
2.00	Less: contractual allowances and discounts on patients accounts	0	2.00
3.00	Net patient revenues (Line 1 minus line 2)	13,748,203	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	18,077,026	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-4,328,823	5.00
Other income:			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,656	7.00
8.00	Revenues from communications (Telephone and Internet service)	8,853	8.00
9.00	Revenue from television and radio service	18,296	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	12,730	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	Other miscellaneous revenue (specify)	0	24.00
24.01	Other Revenue	3,571,771	24.01
25.00	Total other income (Sum of lines 6 - 24)	3,615,306	25.00
26.00	Total (Line 5 plus line 25)	-713,517	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00	Rounding	1	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	1	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-713,518	31.00