

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 3/2/2015 11:39 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 3/2/2015	Time: 11:39 am
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by BLESSING HOSPITAL (140015) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-1,652,702	-10,694	740,816	0	1.00
2.00 Subprovider - IPF	0	184,072	0		0	2.00
3.00 Subprovider - IRF	0	-9,402	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	271,666	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		-26,744		0	10.00
200.00 Total	0	-1,206,366	-37,438	740,816	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 3/2/2015 11:13 am
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
1.00 Street: 1005 BROADWAY		PO Box:		1.00	
2.00 City: QUINCY		State: IL		2.00 Zip Code: 62301	
				County: ADAMS	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	BLESSING PSYCHIATRIC AT 14TH ST	14S015	99914	4	10/01/1993	N	P	O	4.00
5.00	Subprovider - IRF	BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC	GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2013	09/30/2014	20.00	
21.00	Type of Control (see instructions)					2		21.00	

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N	22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N	23.00	

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						
	5,118	0	666	0	561	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.						
	310	0	19	0	7		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 3/2/2015 11:13 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2013	09/30/2014		36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N			39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 3/2/2015 11:13 am																																																																																																																																															
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))																																																																																																																																															
		1.00	2.00	3.00																																																																																																																																															
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(see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></td> <td>N</td> <td>N 0</td> </tr> <tr> <td>75.00</td> <td>Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>Y</td> <td></td> </tr> <tr> <td>76.00</td> <td>If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. 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Enter "Y" for yes and "N" for no.</td> <td colspan="3"></td> <td colspan="2"></td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th colspan="2">V</th> <th colspan="2">XIX</th> <th colspan="2"></th> </tr> <tr> <th colspan="2"></th> <th colspan="2">1.00</th> <th colspan="2">2.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td>90.00</td> <td>Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td colspan="2"></td> <td colspan="2">N</td> <td colspan="2">Y</td> </tr> <tr> <td>91.00</td> <td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</td> <td colspan="2"></td> <td colspan="2">N</td> <td colspan="2">N</td> </tr> <tr> <td>92.00</td> <td>Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.</td> <td colspan="2"></td> <td colspan="2"></td> <td colspan="2">N</td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td colspan="2"></td> <td colspan="2">N</td> <td colspan="2">N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td colspan="2"></td> <td colspan="2">N</td> <td colspan="2">N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td colspan="2"></td> <td colspan="2">0.00</td> <td colspan="2">0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>									1.00	2.00	3.00			70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. 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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 3/2/2015 11:13 am		
		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers	0.00	0.00	97.00		
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00		
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	722,816	1,973,867	0		
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. DO NOT USE THIS LINE		Y			118.02
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		Y		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. Transplant Center Information		Y			121.00
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00

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		1.00	2.00		
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H132	140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 131	
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00	
143.00	City: QUINCY	State: IL		Zip Code: 62301	
				143.00	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y		145.00	
				1.00	
				2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
				1.00	
Multi campus					
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
				CBSA	FTE/Campus
				4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5			0.00	
				1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			Y	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.25	
				1.00	
				2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2013 09/30/2014	
				170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part II Date/Time Prepared: 3/2/2015 11:13 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/31/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140015

Period:
From 10/01/2013
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Worksheet S-2
Part II
Date/Time Prepared:
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE		ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159		CZIEGLER@BLESSINGHOSPITAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-2
Part II
Date/Time Prepared:
3/2/2015 11:13 am

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	12/31/2014	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REVENUE INTEGRITY	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
3/2/2015 11:13 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	164	59,860	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		164	59,860	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	25	9,125	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		189	68,985	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	60	21,900		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		287				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	19,650	4,249	32,837			1.00
2.00 HMO and other (see instructions)	2,062	360				2.00
3.00 HMO IPF Subprovider	112	874				3.00
4.00 HMO IRF Subprovider	287	7				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	19,650	4,249	32,837			7.00
8.00 INTENSIVE CARE UNIT	2,472	557	4,179			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		1,179	2,332			13.00
14.00 Total (see instructions)	22,122	5,985	39,348	17.32	1,768.87	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,622	5,973	12,664	0.26	87.43	16.00
17.00 SUBPROVIDER - IRF	3,551	336	4,927	0.42	28.20	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	4,472	0	5,498	0.00	31.82	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	44,751	0	55,697	0.00	57.01	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	29.96	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	2,234	0	6,561	0.00	8.16	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				18.00	2,011.45	27.00
28.00 Observation Bed Days		1,579	7,308			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			762			30.00
31.00 Employee discount days - IRF			81			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
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Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,171	1,671	10,090	1.00
2.00 HMO and other (see instructions)			444	159		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	5,171	1,671	10,090	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	380	1,002	2,118	16.00
17.00 SUBPROVIDER - IRF	0.00	0	269	25	374	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part II Date/Time Prepared: 3/2/2015 11:13 am			
	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	108,486,409	0	108,486,409	4,164,117.55	26.05	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		928,168	0	928,168	5,747.00	161.50	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		6,522,653	0	6,522,653	23,951.31	272.33	5.00
6.00	Non-physician-Part B		681,619	0	681,619	22,714.07	30.01	6.00
7.00	Interns & residents (in an approved program)	21.00	1,073,675	0	1,073,675	39,629.74	27.09	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,438,581	-39,869	1,398,712	64,407.58	21.72	9.00
10.00	Excluded area salaries (see instructions)		18,197,691	973,785	19,171,476	640,248.92	29.94	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		1,383,811	0	1,383,811	16,589.44	83.42	11.00
12.00	Contract labor: Top level management and other management and administrative services		431,978	0	431,978	1,899.24	227.45	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		4,978,687	0	4,978,687	59,839.13	83.20	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		28,217,825	0	28,217,825			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,426,609	0	6,426,609			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		149,165	0	149,165			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		959,711	0	959,711			23.00
24.00	Wage-related costs (RHC/FQHC)		209,515	0	209,515			24.00
25.00	Interns & residents (in an approved program)		350,810	0	350,810			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	2,530,849	0	2,530,849	162,229.35	15.60	26.00
27.00	Administrative & General	5.00	15,466,991	0	15,466,991	585,316.60	26.42	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	2,397,633	0	2,397,633	115,743.81	20.71	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	61,843	0	61,843	5,368.58	11.52	31.00
32.00	Housekeeping	9.00	2,106,961	0	2,106,961	163,948.12	12.85	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,296,494	-1,652,098	644,396	52,805.80	12.20	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,652,098	1,652,098	135,383.09	12.20	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,033,100	-14,820	5,018,280	192,915.50	26.01	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-3
Part II
Date/Time Prepared:
3/2/2015 11:13 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	2,062,088	0	2,062,088	115,318.93	17.88	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-3
Part III
Date/Time Prepared:
3/2/2015 11:13 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	100,208,462	0	100,208,462	4,077,822.43	24.57	1.00
2.00	Excluded area salaries (see instructions)	19,636,272	933,916	20,570,188	704,656.50	29.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)	80,572,190	-933,916	79,638,274	3,373,165.93	23.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,794,476	0	6,794,476	78,327.81	86.74	4.00
5.00	Subtotal wage-related costs (see inst.)	28,366,990	0	28,366,990	0.00	35.62	5.00
6.00	Total (sum of lines 3 thru 5)	115,733,656	-933,916	114,799,740	3,451,493.74	33.26	6.00
7.00	Total overhead cost (see instructions)	31,955,959	-14,820	31,941,139	1,529,029.78	20.89	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 3/2/2015 11:13 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			3,476,053 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			2,507,122 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)			21,031,347 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)			108,810 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)			204,088 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			891,188 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			7,362,343 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			149,821 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			582,863 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			36,313,635 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part V Date/Time Prepared: 3/2/2015 11:13 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,383,811	36,313,635	1.00
2.00	Hospital	1,383,811	32,337,027	2.00
3.00	Subprovider - IPF	0	1,251,234	3.00
4.00	Subprovider - IRF	0	451,413	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	436,990	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	1,187,557	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	504,175	13.00
14.00	Hospital-Based Health Clinic RHC	0	145,239	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140015 Component CCN: 147031		Period: From 10/01/2013 To 09/30/2014		Worksheet S-4 Date/Time Prepared: 3/2/2015 11:13 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County	ADAMS				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	11,789	0	1,441	13,230	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,216.00	0.00	649.00	1,865.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00			0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				1.00	0.00	4.00
5.00	Other Administrative Personnel				9.85	0.00	5.00
6.00	Direct Nursing Service				21.72	0.00	6.00
7.00	Nursing Supervisor				0.00	0.00	7.00
8.00	Physical Therapy Service				10.19	0.00	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	9.00
10.00	Occupational Therapy Service				3.39	0.00	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	11.00
12.00	Speech Pathology Service				0.66	0.00	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	13.00
14.00	Medical Social Service				1.73	0.00	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	15.00
16.00	Home Health Aide				6.36	0.00	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				2		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				99914		20.00
20.01					99926		20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (col s. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	17,991	3,876	472	368	22,707	21.00
22.00	Skilled Nursing Visit Charges	2,428,755	557,138	48,511	49,245	3,083,649	22.00
23.00	Physical Therapy Visits	10,447	560	65	179	11,251	23.00
24.00	Physical Therapy Visit Charges	1,493,669	81,732	8,526	25,725	1,609,652	24.00
25.00	Occupational Therapy Visits	3,317	387	26	84	3,814	25.00
26.00	Occupational Therapy Visit Charges	481,719	56,889	3,087	12,348	554,043	26.00
27.00	Speech Pathology Visits	482	51	9	2	544	27.00
28.00	Speech Pathology Visit Charges	67,326	7,350	1,029	294	75,999	28.00
29.00	Medical Social Service Visits	69	2	0	0	71	29.00
30.00	Medical Social Service Visit Charges	9,996	294	0	0	10,290	30.00
31.00	Home Health Aide Visits	4,309	1,974	8	73	6,364	31.00
32.00	Home Health Aide Visit Charges	345,221	159,408	410	5,658	510,697	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	36,615	6,850	580	706	44,751	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	4,826,686	862,811	61,563	93,270	5,844,330	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,788		151	37	1,976	36.00
37.00	Total Number of Outlier Episodes		117		4	121	37.00
38.00	Total Non-Routine Medical Supply Charges	28,821	30,842	1,317	786	61,766	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-7

Date/Time Prepared:
3/2/2015 11:13 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	6	0	6	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	176	0	176	7.00
8.00	RHL	55	0	55	8.00
9.00	RMX	74	0	74	9.00
10.00	RML	19	0	19	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	146	0	146	15.00
16.00	RVB	15	0	15	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	1,453	0	1,453	18.00
19.00	RHB	1,175	0	1,175	19.00
20.00	RHA	172	0	172	20.00
21.00	RMC	254	0	254	21.00
22.00	RMB	127	0	127	22.00
23.00	RMA	67	0	67	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	135	0	135	28.00
29.00	HE2	47	0	47	29.00
30.00	HE1	10	0	10	30.00
31.00	HD2	46	0	46	31.00
32.00	HD1	98	0	98	32.00
33.00	HC2	14	0	14	33.00
34.00	HC1	53	0	53	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	52	0	52	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	16	0	16	39.00
40.00	LD1	32	0	32	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	33	0	33	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	17	0	17	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	7	0	7	46.00
47.00	CD2	16	0	16	47.00
48.00	CD1	11	0	11	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	41	0	41	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	17	0	17	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	62	0	62	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	4	0	4	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-7

Date/Time Prepared:
3/2/2015 11:13 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	12	0	12	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	4	0	4	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	3	0	3	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,472	0	4,472	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00
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		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

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 202 through 207: 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 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	1,438,581	31.49	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,567,712			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 3/2/2015 11:13 am		
			Rural Health Clinic (RHC) I	Cost		
			1.00			
1.00	Clinic Address and Identification Street		102 PRAIRIE MILLS ROAD		1.00	
		City	State	Zip Code		
		1.00	2.00	3.00		
2.00	City, State, Zip Code, County		GOLDEN	IL62339	2.00	
			1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00	
			Grant Award	Date		
			1.00	2.00		
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00	
7.00	Appalachian Regional Commission		0		7.00	
8.00	Look-Alikes		0		8.00	
9.00	OTHER (SPECIFY)		0		9.00	
			1.00			
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00	
		Sunday	Monday	Tuesday		
		from to	from to	from		
		1.00 2.00	3.00 4.00	5.00		
11.00	Facility hours of operations (1) Clinic		09:00	17:00	09:00 11.00	
			1.00			
			2.00			
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N		0 13.00	
			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number				14.00	
		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		N	0	0	0 15.00
			County			
			4.00			
2.00	City, State, Zip Code, County		ADAMS		2.00	
		Tuesday	Wednesday	Thursday		
		to	from to	from to		
		6.00	7.00 8.00	9.00 10.00		
11.00	Facility hours of operations (1) Clinic		17:00	09:00	17:00 09:00 17:00 11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 3/2/2015 11:13 am	
			Rural Health Clinic (RHC) I	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	09:00	17:00		11.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140015 Component CCN: 141501	Period: From 10/01/2013 To 09/30/2014	Worksheet S-9 Parts I & II Date/Time Prepared: 3/2/2015 11:13 am
		Hospice I		

	Unduplicated Days	Hospice I				Total (sum of col.s. 1, 2 & 5)		
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			All Other
		1.00	2.00	3.00	4.00			5.00
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	14,174	633	0	3,991	706	15,513	2.00
3.00	Inpatient Respite Care	14	3	0	0	0	17	3.00
4.00	General Inpatient Care	95	44	0	0	26	165	4.00
5.00	Total Hospice Days	14,283	680	0	3,991	732	15,695	5.00
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	433	28	0	6	44	505	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	32.99	24.29	0.00	665.17	16.64	31.08	8.00
9.00	Unduplicated Census Count	346	28	0	6	44	418	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet S-10 Date/Time Prepared: 3/2/2015 11:13 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.250247	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		20,059,732	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		8,081,531	5.00	
6.00	Medicaid charges		142,696,086	6.00	
7.00	Medicaid cost (line 1 times line 6)		35,709,267	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		7,568,004	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		7,568,004	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	31,007,179	111,330,133	142,337,312	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,759,454	27,860,032	35,619,486	21.00
22.00	Partial payment by patients approved for charity care	21,213	74,765	95,978	22.00
23.00	Cost of charity care (line 21 minus line 22)	7,738,241	27,785,267	35,523,508	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		16,685,853	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,095,662	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		15,590,191	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,901,399	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		39,424,907	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		46,992,911	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 140015		Period: From 10/01/2013 To 09/30/2014		Worksheet A Date/Time Prepared: 3/2/2015 11:13 am	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)			
	1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS								
1.00 00100	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00		
1.01 00101	CAP REL COSTS-BUTLER BUILDING	5,062	5,062	22,384	27,446	1.01		
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT	273,467	273,467	42,993	316,460	1.02		
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT	3,219,518	3,219,518	490,283	3,709,801	1.03		
1.04 00104	CAP REL COSTS-14TH STREET	256,643	256,643	1,111,392	1,368,035	1.04		
1.05 00105	CAP REL COSTS-MOB PHASE I	0	0	107,344	107,344	1.05		
2.00 00200	CAP REL COSTS-MVBLE EQUIP	11,875,182	11,875,182	374,628	12,249,810	2.00		
3.00 00300	OTHER CAP REL COSTS	0	0	0	0	3.00		
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,530,849	38,147,092	40,677,941	40,677,941	4.00		
5.00 00500	ADMINISTRATIVE & GENERAL	15,466,991	58,035,657	73,502,648	193,166	73,695,814	5.00	
6.00 00600	MAINTENANCE & REPAIRS	2,397,633	4,425,678	6,823,311	0	6,823,311	6.00	
8.00 00800	LAUNDRY & LINEN SERVICE	61,843	1,008,767	1,070,610	0	1,070,610	8.00	
9.00 00900	HOUSEKEEPING	2,106,961	411,419	2,518,380	0	2,518,380	9.00	
10.00 01000	DIETARY	2,296,494	3,610,945	5,907,439	-4,249,812	1,657,627	10.00	
11.00 01100	CAFETERIA	0	0	0	4,249,812	4,249,812	11.00	
13.00 01300	NURSING ADMINISTRATION	5,033,100	845,764	5,878,864	-14,820	5,864,044	13.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	2,062,088	933,317	2,995,405	0	2,995,405	16.00	
20.00 02000	NURSING SCHOOL	3,046,343	1,450,779	4,497,122	989,047	5,486,169	20.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,073,675	0	1,073,675	0	1,073,675	21.00	
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,172,765	2,172,765	0	2,172,765	22.00	
23.00 02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00	
23.01 02301	PARAMED ED PRGM-RADIOLOGY	246,565	11,229	257,794	0	257,794	23.01	
23.02 02302	PARAMED ED PRGM-LABORATORY	62,769	2,800	65,569	0	65,569	23.02	
23.03 02303	PARAMED ED PRGM-PHARMACY	59,543	8,244	67,787	16,316	84,103	23.03	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 03000	ADULTS & PEDIATRICS	13,962,512	2,283,978	16,246,490	-746,086	15,500,404	30.00	
31.00 03100	INTENSIVE CARE UNIT	3,339,259	1,589,344	4,928,603	-308,376	4,620,227	31.00	
40.00 04000	SUBPROVIDER - IPF	4,046,787	121,622	4,168,409	-42,782	4,125,627	40.00	
41.00 04100	SUBPROVIDER - IRF	1,449,415	145,188	1,594,603	-19,626	1,574,977	41.00	
43.00 04300	NURSERY	441,288	75,621	516,909	-97,953	418,956	43.00	
44.00 04400	SKILLED NURSING FACILITY	1,438,581	126,980	1,565,561	-60,100	1,505,461	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00 05000	OPERATING ROOM	8,186,831	15,671,581	23,858,412	-11,219,042	12,639,370	50.00	
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,166,907	568,855	1,735,762	-124,155	1,611,607	52.00	
53.00 05300	ANESTHESIOLOGY	188,232	500,394	688,626	-195,453	493,173	53.00	
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,947,262	2,809,990	7,757,252	-272,107	7,485,145	54.00	
60.00 06000	LABORATORY	2,903,028	2,780,168	5,683,196	-49,508	5,633,688	60.00	
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	111,534	1,096,045	1,207,579	0	1,207,579	62.00	
65.00 06500	RESPIRATORY THERAPY	1,971,909	369,222	2,341,131	-110,235	2,230,896	65.00	
66.00 06600	PHYSICAL THERAPY	1,358,591	23,651	1,382,242	-698	1,381,544	66.00	
67.00 06700	OCCUPATIONAL THERAPY	514,162	6,041	520,203	-519	519,684	67.00	
68.00 06800	SPEECH PATHOLOGY	254,965	10,928	265,893	-1,863	264,030	68.00	
69.00 06900	ELECTROCARDIOLOGY	1,609,913	4,464,196	6,074,109	-3,746,065	2,328,044	69.00	
70.00 07000	ELECTROENCEPHALOGRAPHY	277,648	60,946	338,594	0	338,594	70.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	676,833	597,405	1,274,238	5,957,475	7,231,713	71.00	
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,110,724	10,110,724	72.00	
73.00 07300	DRUGS CHARGED TO PATIENTS	3,293,084	12,550,382	15,843,466	-16,343	15,827,123	73.00	
74.00 07400	RENAL DIALYSIS	0	411,293	411,293	-579	410,714	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00 08800	RURAL HEALTH CLINIC	420,393	537,708	958,101	-1,520	956,581	88.00	
90.00 09000	CLINIC	280,449	99,978	380,427	0	380,427	90.00	
91.00 09100	EMERGENCY	9,915,703	696,588	10,612,291	-25,931	10,586,360	91.00	
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00 10100	HOME HEALTH AGENCY	3,801,114	1,546,857	5,347,971	-1,678	5,346,293	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00 11300	INTEREST EXPENSE	0	2,374,965	2,374,965	-2,374,965	0	113.00	
116.00 11600	HOSPICE	1,613,754	595,486	2,209,240	-168	2,209,072	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	104,615,008	178,809,740	283,424,748	-14,820	283,409,928	118.00	
NONREIMBURSABLE COST CENTERS								
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,283,141	236,606	3,519,747	0	3,519,747	192.00	
192.01 19201	FASTCARE	413,503	115,577	529,080	0	529,080	192.01	
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00	
193.02 19302	DENMAN SERVICES	0	0	0	0	0	193.02	
193.03 19303	MEALS ON WHEELS	0	0	0	0	0	193.03	
193.04 19304	UNUSED SPACE	0	0	0	0	0	193.04	
193.05 19305	HEALTH EDUCATION	0	0	0	14,820	14,820	193.05	
193.06 19306	RENTED SPACE	0	0	0	0	0	193.06	
193.07 19307	AUGUSTA PHARMACY	174,757	633,490	808,247	0	808,247	193.07	
200.00	TOTAL (SUM OF LINES 118-199)	108,486,409	179,795,413	288,281,822	0	288,281,822	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	27,446	1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT	0	316,460	1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT	-549,500	3,160,301	1.03
1.04	00104	CAP REL COSTS-14TH STREET	-1,111,390	256,645	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	-81,214	26,130	1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-488,386	11,761,424	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-23,276,745	17,401,196	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-34,296,933	39,398,881	5.00
6.00	00600	MAINTENANCE & REPAIRS	-601,654	6,221,657	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-9,023	1,061,587	8.00
9.00	00900	HOUSEKEEPING	-294,200	2,224,180	9.00
10.00	01000	DIETARY	-1,013,421	644,206	10.00
11.00	01100	CAFETERIA	-1,503,275	2,746,537	11.00
13.00	01300	NURSING ADMINISTRATION	-225,761	5,638,283	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-339,500	2,655,905	16.00
20.00	02000	NURSING SCHOOL	-3,283,570	2,202,599	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,073,675	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,172,765	22.00
23.00	02300	PARAMED ED PRGM-(SPECFY)	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-68,446	189,348	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-21,712	43,857	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	84,103	23.03
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-8,148	15,492,256	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,395,155	3,225,072	31.00
40.00	04000	SUBPROVIDER - I PF	0	4,125,627	40.00
41.00	04100	SUBPROVIDER - I RF	-13,874	1,561,103	41.00
43.00	04300	NURSERY	0	418,956	43.00
44.00	04400	SKILLED NURSING FACILITY	-805	1,504,656	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,248,422	11,390,948	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,611,607	52.00
53.00	05300	ANESTHESIOLOGY	0	493,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-13	7,485,132	54.00
60.00	06000	LABORATORY	-64,756	5,568,932	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,207,579	62.00
65.00	06500	RESPIRATORY THERAPY	-34,600	2,196,296	65.00
66.00	06600	PHYSICAL THERAPY	-19,561	1,361,983	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	519,684	67.00
68.00	06800	SPEECH PATHOLOGY	0	264,030	68.00
69.00	06900	ELECTROCARDIOLOGY	-30,869	2,297,175	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-41,090	297,504	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,231,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,110,724	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,309,528	13,517,595	73.00
74.00	07400	RENAL DIALYSIS	0	410,714	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-41,705	914,876	88.00
90.00	09000	CLINIC	21,207	401,634	90.00
91.00	09100	EMERGENCY	-5,973,076	4,613,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-10,150	5,336,143	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-27,952	2,181,120	116.00
118.00	11800	SUBTOTALS (SUM OF LINES 1-117)	-78,363,227	205,046,701	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,519,747	192.00
192.01	19201	FASTCARE	0	529,080	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	14,820	193.05
193.06	19306	RENTED SPACE	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	808,247	193.07
200.00	20000	TOTAL (SUM OF LINES 118-199)	-78,363,227	209,918,595	200.00

RECLASSIFICATIONS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-6
Date/Time Prepared:
3/2/2015 11:13 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - RECLASS CAFETERIA COSTS						
1.00	CAFETERIA	11.00	1,652,098	2,597,714	1.00	
	TOTALS		1,652,098	2,597,714		
B - RECLASS C-SECTION COSTS						
1.00	OPERATING ROOM	50.00	11,555	0	1.00	
	TOTALS		11,555	0		
D - RECLASS CAPITAL RELATED INSURANCE						
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	22,384	1.00	
2.00	CAP REL COSTS-OLD BUILDING & FIXT	1.02	0	42,993	2.00	
3.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	62,102	3.00	
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,201	4.00	
	TOTALS		0	135,680		
E - RECLASS PHARMACY RESIDENT SALARIES						
1.00	PARAMED ED PRGM-PHARMACY	23.03	16,316	0	1.00	
	TOTALS		16,316	0		
F - RECLASS HEALTH EDUCATION						
1.00	HEALTH EDUCATION	193.05	14,820	0	1.00	
	TOTALS		14,820	0		
G - RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0	428,181	1.00	
2.00	CAP REL COSTS-14TH STREET	1.04	0	1,111,392	2.00	
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	366,427	3.00	
4.00	ADMINISTRATIVE & GENERAL	5.00	0	468,965	4.00	
	TOTALS		0	2,374,965		
H - RECLASS ER PHYSICIAN MALPRACTICE INS						
1.00	EMERGENCY	91.00	0	105,524	1.00	
	TOTALS		0	105,524		
I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,957,475	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,110,724	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
	TOTALS		0	16,068,199		
J - RECLASS PRECEPTOR PAY						
1.00	NURSING SCHOOL	20.00	989,047	0	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
	TOTALS		989,047	0		
K - RECLASS RENT EXPENSE						
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	107,344	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	107,344		
500.00	Grand Total: Increases		2,683,836	21,389,426	500.00	

RECLASSIFICATIONS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-6
Date/Time Prepared:
3/2/2015 11:13 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,652,098	2,597,714	0	1.00
	TOTALS		1,652,098	2,597,714		
B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	11,555	0	0	1.00
	TOTALS		11,555	0		
D - RECLASS CAPITAL RELATED INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	135,680	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	12	3.00
4.00		0.00	0	0	12	4.00
	TOTALS		0	135,680		
E - RECLASS PHARMACY RESIDENT SALARIES						
1.00	DRUGS CHARGED TO PATIENTS	73.00	16,316	0	0	1.00
	TOTALS		16,316	0		
F - RECLASS HEALTH EDUCATION						
1.00	NURSING ADMINISTRATION	13.00	14,820	0	0	1.00
	TOTALS		14,820	0		
G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,374,965	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	11	3.00
4.00		0.00	0	0	11	4.00
	TOTALS		0	2,374,965		
H - RECLASS ER PHYSICIAN MALPRACTICE INS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	105,524	0	1.00
	TOTALS		0	105,524		
I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	230,071	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	128,429	0	2.00
3.00	SUBPROVIDER - IPF	40.00	0	925	0	3.00
4.00	SUBPROVIDER - IRF	41.00	0	15,085	0	4.00
5.00	NURSERY	43.00	0	40,399	0	5.00
6.00	SKILLED NURSING FACILITY	44.00	0	20,231	0	6.00
7.00	OPERATING ROOM	50.00	0	11,084,920	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	86,037	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	195,453	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	272,107	0	10.00
11.00	LABORATORY	60.00	0	49,508	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	110,235	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	698	0	13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	519	0	14.00
15.00	SPEECH PATHOLOGY	68.00	0	1,863	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	3,739,832	0	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	27	0	17.00
18.00	RENAL DIALYSIS	74.00	0	579	0	18.00
19.00	RURAL HEALTH CLINIC	88.00	0	1,520	0	19.00
20.00	EMERGENCY	91.00	0	87,915	0	20.00
21.00	HOME HEALTH AGENCY	101.00	0	1,678	0	21.00
22.00	HOSPICE	116.00	0	168	0	22.00
	TOTALS		0	16,068,199		
J - RECLASS PRECEPTOR PAY						
1.00	ADULTS & PEDIATRICS	30.00	516,015	0	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	179,947	0	0	2.00
3.00	SUBPROVIDER - IPF	40.00	41,857	0	0	3.00
4.00	SUBPROVIDER - IRF	41.00	4,541	0	0	4.00
5.00	NURSERY	43.00	57,554	0	0	5.00
6.00	SKILLED NURSING FACILITY	44.00	39,869	0	0	6.00
7.00	OPERATING ROOM	50.00	72,928	0	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	26,563	0	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	6,233	0	0	9.00
10.00	EMERGENCY	91.00	43,540	0	0	10.00
	TOTALS		989,047	0		
K - RECLASS RENT EXPENSE						
1.00	OPERATING ROOM	50.00	0	72,749	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	34,595	10	2.00
	TOTALS		0	107,344		
500.00	Grand Total: Decreases		2,683,836	21,389,426		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
3/2/2015 11:13 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	13,119,734	99,847	0	99,847	68,811 1.00
2.00	Land Improvements	6,558,946	464,865	0	464,865	0 2.00
3.00	Buildings and Fixtures	100,705,202	3,598,118	0	3,598,118	0 3.00
4.00	Building Improvements	3,564,673	0	0	0	0 4.00
5.00	Fixed Equipment	37,178,894	1,547,218	0	1,547,218	0 5.00
6.00	Movable Equipment	150,390,480	10,200,308	0	10,200,308	102,529 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	311,517,929	15,910,356	0	15,910,356	171,340 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	311,517,929	15,910,356	0	15,910,356	171,340 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	13,150,770	0			1.00
2.00	Land Improvements	7,023,811	0			2.00
3.00	Buildings and Fixtures	104,303,320	0			3.00
4.00	Building Improvements	3,564,673	0			4.00
5.00	Fixed Equipment	38,726,112	0			5.00
6.00	Movable Equipment	160,488,259	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	327,256,945	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	327,256,945	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	5,062	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	273,467	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	3,219,518	0	0	0	0	1.03
1.04	CAP REL COSTS-14TH STREET	256,643	0	0	0	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	11,875,182	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	15,629,872	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	5,062				1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	273,467				1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	3,219,518				1.03
1.04	CAP REL COSTS-14TH STREET	0	256,643				1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0				1.05
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,875,182				2.00
3.00	Total (sum of lines 1-2)	0	15,629,872				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	307,247	0	307,247	0.001364	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	9,095,325	0	9,095,325	0.040383	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	39,282,386	0	39,282,386	0.174414	0	1.03
1.04	CAP REL COSTS-14TH STREET	16,051,221	0	16,051,221	0.071268	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	160,488,259	0	160,488,259	0.712571	0	2.00
3.00	Total (sum of lines 1-2)	225,224,438	0	225,224,438	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	5,062	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	0	0	273,467	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	0	0	3,098,199	0	1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	256,643	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	26,130	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,758,795	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,392,166	26,130	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	22,384	0	0	27,446	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIXT	0	42,993	0	0	316,460	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIXT	0	62,102	0	0	3,160,301	1.03
1.04	CAP REL COSTS-14TH STREET	2	0	0	0	256,645	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	26,130	1.05
2.00	CAP REL COSTS-MVBLE EQUIP	-5,572	8,201	0	0	11,761,424	2.00
3.00	Total (sum of lines 1-2)	-5,570	135,680	0	0	15,548,406	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-8

Date/Time Prepared:
3/2/2015 11:13 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)			OCAP REL COSTS-BUTLER BUILDING	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-OLD BUILDING & FIXT (chapter 2)			OCAP REL COSTS-OLD BUILDING & FIXT	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-NEW BUILDING & FIXT (chapter 2)			OCAP REL COSTS-NEW BUILDING & FIXT	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-14TH STREET (chapter 2)			OCAP REL COSTS-14TH STREET	1.04	0	1.04
1.05	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)			OCAP REL COSTS-MOB PHASE I	1.05	0	1.05
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-422,690	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-185,471	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-53,370	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-21,712,934			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,559,298			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,503,275	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	A	-2,255,958	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-104,836	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-3,231,378	NURSING SCHOOL	20.00	0	19.00
20.00	Vending machines	B	-65,632	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING			OCAP REL COSTS-BUTLER BUILDING	1.01	0	26.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-8

Date/Time Prepared:
3/2/2015 11:13 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
				Cost Center		Line #	
				1.00	2.00	3.00	
26.02	Depreciation - CAP REL COSTS-OLD BUILDING & FIXT			0	CAP REL COSTS-OLD BUILDING & FIXT	1.02	0 26.02
26.03	Depreciation - CAP REL COSTS-NEW BUILDING & FIXT			0	CAP REL COSTS-NEW BUILDING & FIXT	1.03	0 26.03
26.04	Depreciation - CAP REL COSTS-14TH STREET			0	CAP REL COSTS-14TH STREET	1.04	0 26.04
26.05	Depreciation - CAP REL COSTS-MOB PHASE I			0	CAP REL COSTS-MOB PHASE I	1.05	0 26.05
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	0 28.00
29.00	Physicians' assistant			0		0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	0 30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	0 30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	0 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00	RENTAL INSURANCE EXPENSE	A	-9,008		ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01	DAMAGED GOODS	B	32,248		ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02	CHILD CARE CENTER	B	-1,724,742		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.02
33.03	BOOKKEEPING FEES	B	-137,368		ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04	RADIOLOGY TUITION	B	-68,446		PARAMED ED PRGM-RADIOLOGY	23.01	0 33.04
33.05	PRINT SHOP	B	-62,819		ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06	HEALTH PROMOTIONS	B	-129,964		NURSING ADMINISTRATIVE	13.00	0 33.06
33.07	HOUSEKEEPING SERVICES	B	-294,200		HOUSEKEEPING	9.00	0 33.07
33.08	ADVERTISING	A	-349,123		ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09	RENTAL PROPERTY EXPENSE	A	-195,606		CAP REL COSTS-NEW BUILDING & FIXT	1.03	9 33.09
33.10	RENTAL PROPERTY EXPENSE	A	-5,571		CAP REL COSTS-MVBLE EQUIP	2.00	11 33.10
33.11	REAL ESTATE TAXES ON RENTAL	A	-75,841		MAINTENANCE & REPAIRS	6.00	0 33.11
33.12	RENTAL PROPERTY EXPENSE	A	-52,582		MAINTENANCE & REPAIRS	6.00	0 33.12
33.13	INTEREST INCOME	A	-428,181		CAP REL COSTS-NEW BUILDING & FIXT	1.03	11 33.13
33.14	INTEREST INCOME	A	-1,111,390		CAP REL COSTS-14TH STREET	1.04	11 33.14
33.15	INTEREST INCOME	A	-366,428		CAP REL COSTS-MVBLE EQUIP	2.00	11 33.15
33.16	INTEREST INCOME	A	-468,965		ADMINISTRATIVE & GENERAL	5.00	0 33.16
33.17	DIETARY OUTSIDE SERVICES-SALARIES	A	-37,446		DIETARY	10.00	0 33.17
33.18	DIETARY OUTSIDE SERVICES-BENEFITS	A	-12,567		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.18
33.19	PHYSICIAN RECRUITMENT	A	-673,957		ADMINISTRATIVE & GENERAL	5.00	0 33.19
33.20	NURSING SCHOOL ADVERTISING	A	-22,192		NURSING SCHOOL	20.00	0 33.20
33.21	LOBBYING EXPENSE	A	-53,195		ADMINISTRATIVE & GENERAL	5.00	0 33.21
33.22	TRANSFER TO PARENT	A	-369,764		ADMINISTRATIVE & GENERAL	5.00	0 33.22
33.23	HOSPICE PROFESSIONAL FEES	A	-27,952		HOSPICE	116.00	0 33.23
33.24	HOME CARE PROFESSIONAL FEES	A	-150		HOME HEALTH AGENCY	101.00	0 33.24
33.25	HOME CARE PROFESSIONAL FEES	A	-10,000		HOME HEALTH AGENCY	101.00	0 33.25
33.26	PHYSICIAN BENEFITS	A	-529,580		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.26
33.27	ALCOHOL RELATED EXPENSES	A	-3,000		ADMINISTRATIVE & GENERAL	5.00	0 33.27
33.28	BOOK TO MEDICARE DEPRECIATION	A	74,287		CAP REL COSTS-NEW BUILDING & FIXT	1.03	9 33.28
33.29	GROUND FEES	B	-64,478		MAINTENANCE & REPAIRS	6.00	0 33.29
33.30	LABORATORY TUITION	B	-21,712		PARAMED ED PRGM-LABORATORY	23.02	0 33.30
33.31	CV SURGEON BENEFITS	A	-85,775		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.31
33.32	SELF-FUNDED HEALTH INSURANCE	A	-18,501,227		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.32
33.33	LEASED EQUIPMENT	B	-4,332		CAP REL COSTS-MVBLE EQUIP	2.00	9 33.33
33.34	STUDER GROUP EXPENSE	A	-349,350		ADMINISTRATIVE & GENERAL	5.00	0 33.34
33.35	TRAUMA ON-CALL	A	-807,629		ADMINISTRATIVE & GENERAL	5.00	0 33.35
33.36	NON-HOSPITAL DEPRECIATION	A	-58,685		CAP REL COSTS-MVBLE EQUIP	2.00	9 33.36
33.37	MISCELLANEOUS INCOME	B	-64,096		ADMINISTRATIVE & GENERAL	5.00	0 33.37
33.38	MISCELLANEOUS INCOME	B	-1,821		OPERATING ROOM	50.00	0 33.38
33.39	MISCELLANEOUS INCOME	B	-18,101		RESPIRATORY THERAPY	65.00	0 33.39
33.40	MISCELLANEOUS INCOME	B	-36,417		ELECTROENCEPHALOGRAPHY	70.00	0 33.40
33.41	MISCELLANEOUS INCOME	B	-5,600		RESPIRATORY THERAPY	65.00	0 33.41
33.42	MISCELLANEOUS INCOME	B	-16,575		ADMINISTRATIVE & GENERAL	5.00	0 33.42

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.43	MI SCCELLANEOUS INCOME	B	-830,768	ADMINISTRATIVE & GENERAL	5.00	0 33.43
33.44	MI SCCELLANEOUS INCOME	B	-4,756	LABORATORY	60.00	0 33.44
33.45	MI SCCELLANEOUS INCOME	B	-13	RADIOLOGY-DIAGNOSTIC	54.00	0 33.45
33.46	MI SCCELLANEOUS INCOME	B	-9,634	ELECTROCARDIOLOGY	69.00	0 33.46
33.47	MI SCCELLANEOUS INCOME	B	-19,561	PHYSICAL THERAPY	66.00	0 33.47
33.48	MI SCCELLANEOUS INCOME	B	-5,835	MEDICAL RECORDS & LIBRARY	16.00	0 33.48
33.49	CARE COORDINATION	B	-52,623	ADMINISTRATIVE & GENERAL	5.00	0 33.49
33.50	MI SCCELLANEOUS INCOME	B	-134,381	ADMINISTRATIVE & GENERAL	5.00	0 33.50
33.51	MI SCCELLANEOUS INCOME	B	-35,428	ADMINISTRATIVE & GENERAL	5.00	0 33.51
33.52	MI SCCELLANEOUS INCOME	B	23,760	CLINIC	90.00	0 33.52
33.53	CATERING REVENUE	B	-437,451	DIETARY	10.00	0 33.53
33.54	FLOOR STOCK REVENUE	B	-257,363	DIETARY	10.00	0 33.54
33.55	BH JAVA	B	-215,529	DIETARY	10.00	0 33.55
33.56	BPS EXPENSES	A	-15,100,437	ADMINISTRATIVE & GENERAL	5.00	0 33.56
33.57	ECHO OUTREACH SALARIES	A	-10,871	ELECTROCARDIOLOGY	69.00	0 33.57
33.58	ECHO OUTREACH BENEFITS	A	-3,648	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.58
33.59	PHARMACY COVERAGE SALARIES	A	-31,172	DRUGS CHARGED TO PATIENTS	73.00	0 33.59
33.60	PHARMACY COVERAGE BENEFITS	A	-10,461	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.60
33.61	PHARMACY COVERAGE EXPENSES	A	-22,398	DRUGS CHARGED TO PATIENTS	73.00	0 33.61
33.62	INFORMATION SYSTEMS-WAGES	A	-4,025,075	ADMINISTRATIVE & GENERAL	5.00	0 33.62
33.63	INFORMATION SYSTEMS-BENEFITS	A	-1,534,298	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.63
33.64	MEDICAL RECORDS-SALARIES	A	-78,762	MEDICAL RECORDS & LIBRARY	16.00	0 33.64
33.65	MEDICAL RECORDS-BENEFITS	A	-26,432	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.65
33.66	MEDICAL RECORDS-EXPENSES	A	-35,653	MEDICAL RECORDS & LIBRARY	16.00	0 33.66
33.67	PAIN MGMT-NP SALARIES	A	-55,683	OPERATING ROOM	50.00	0 33.67
33.68	PAIN MGMT-NP BENEFITS	A	-18,687	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.68
33.69	NP AND PA IN URGENT CARE-SALARIES	A	-205,542	EMERGENCY	91.00	0 33.69
33.70	NP AND PA IN URGENT CARE BENEFITS	A	-68,980	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.70
33.71	COLLEGE OF NURSING LOBBYING	A	-30,000	NURSING SCHOOL	20.00	0 33.71
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-78,363,227			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 140015

Period: From 10/01/2013 To 09/30/2014

Worksheet A-8-1

Date/Time Prepared: 3/2/2015 11:13 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	6.00	MAINTENANCE & REPAIRS	BIO-MED	511,447	920,200	1.00
2.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	982,513	991,536	2.00
3.00	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	31,963	73,668	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	11,199,778	7,783,259	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	-631,379	0	4.01
4.02	1.05	CAP REL COSTS-MOB PHASE I	SURGERY RENT	17,787	72,749	4.02
4.03	1.05	CAP REL COSTS-MOB PHASE I	CARE COORDINATION RENT	8,343	34,595	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	PFS AND PT ACCESS COSTS	0	351,026	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	PFS AND PT ACCESS BENEFITS	0	58,950	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	0	4,925	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	ACCOUNTS PAYABLE BENEFITS	0	1,653	4.07
4.08	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS COSTS	0	114,414	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	MEDICAL RECORDS BENEFITS	0	26,432	4.09
4.10	13.00	NURSING ADMINISTRATION	INFORMATICS/CARE MGMT COSTS	0	95,797	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	INFORMATICS/CARE MGMT BENEFIT	0	31,950	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,120,452	10,561,154	5.00

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

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

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

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

6.00	G		0.00	DENMAN SERVICES	0.00	6.00
7.00	G		0.00	DENMAN SERVICES	0.00	7.00
8.00	G		0.00	BLESSING FOUND	0.00	8.00
9.00	B		0.00	BLESS CORP SVCS	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				100.00

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

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

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

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-8-1

Date/Time Prepared:
3/2/2015 11:13 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-408,753	0		1.00
2.00	-9,023	0		2.00
3.00	-41,705	0		3.00
4.00	3,416,519	0		4.00
4.01	-631,379	0		4.01
4.02	-54,962	10		4.02
4.03	-26,252	10		4.03
4.04	-351,026	0		4.04
4.05	-58,950	0		4.05
4.06	-4,925	0		4.06
4.07	-1,653	0		4.07
4.08	-114,414	0		4.08
4.09	-26,432	0		4.09
4.10	-95,797	0		4.10
4.11	-31,950	0		4.11
5.00	1,559,298			5.00

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

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

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

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

6.00	BIO-MED MAINT		6.00
7.00	LAUNDRY		7.00
8.00	FUND RAISING		8.00
9.00	HOME OFFICE		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-8-2

Date/Time Prepared:
3/2/2015 11:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,992,582	1,856,095	120,860	159,800	844	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	165,426	0	165,426	208,000	1,028	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	2,209,149	2,209,149	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	9,984	9,984	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	16,829	0	16,829	159,800	113	6.00
7.00	31.00	INTENSIVE CARE UNIT	1,225,430	1,225,430	0	0	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	169,725	169,725	0	0	0	8.00
9.00	41.00	SUBPROVIDER - IRF	36,000	0	36,000	159,800	288	9.00
10.00	44.00	SKILLED NURSING FACILITY	1,650	0	1,650	159,800	11	10.00
11.00	50.00	OPERATING ROOM	21,200	0	21,200	159,800	106	11.00
12.00	60.00	LABORATORY	60,000	60,000	0	0	0	12.00
13.00	65.00	RESPIRATORY THERAPY	11,325	0	11,325	159,800	76	13.00
14.00	65.00	RESPIRATORY THERAPY	11,175	0	11,175	159,800	75	14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	9,625	0	9,625	159,800	77	15.00
16.00	69.00	ELECTROCARDIOLOGY	7,280	0	7,280	159,800	56	16.00
17.00	69.00	ELECTROCARDIOLOGY	17,850	0	17,850	182,900	119	17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	2,500	0	2,500	159,800	20	18.00
19.00	91.00	EMERGENCY	29,250	0	29,250	159,800	240	19.00
20.00	91.00	EMERGENCY	68,000	0	68,000	159,800	340	20.00
21.00	91.00	EMERGENCY	5,548,544	5,548,544	0	0	0	21.00
22.00	91.00	EMERGENCY	312,440	0	312,440	159,800	1,988	22.00
23.00	91.00	EMERGENCY	6,592	6,592	0	0	0	23.00
24.00	50.00	OPERATING ROOM	16,350	16,350	0	0	0	24.00
25.00	90.00	CLINIC	6,625	0	6,625	159,800	53	25.00
26.00	50.00	OPERATING ROOM	90,133	0	90,133	182,900	313	26.00
27.00	5.00	ADMINISTRATIVE & GENERAL	9,038,512	9,038,512	0	0	0	27.00
28.00	50.00	OPERATING ROOM	124,793	124,793	0	0	0	28.00
29.00	50.00	OPERATING ROOM	974,109	974,109	0	0	0	29.00
200.00			22,183,078	21,239,283	928,168		5,747	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	64,842	3,242	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	102,800	5,140	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	8,681	434	0	0	0	6.00
7.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	8.00
9.00	41.00	SUBPROVIDER - IRF	22,126	1,106	0	0	0	9.00
10.00	44.00	SKILLED NURSING FACILITY	845	42	0	0	0	10.00
11.00	50.00	OPERATING ROOM	8,144	407	0	0	0	11.00
12.00	60.00	LABORATORY	0	0	0	0	0	12.00
13.00	65.00	RESPIRATORY THERAPY	5,839	292	0	0	0	13.00
14.00	65.00	RESPIRATORY THERAPY	5,762	288	0	0	0	14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	5,916	296	0	0	0	15.00
16.00	69.00	ELECTROCARDIOLOGY	4,302	215	0	0	0	16.00
17.00	69.00	ELECTROCARDIOLOGY	10,464	523	0	0	0	17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	1,536	77	0	0	0	18.00
19.00	91.00	EMERGENCY	18,439	922	0	0	0	19.00
20.00	91.00	EMERGENCY	26,121	1,306	0	0	0	20.00
21.00	91.00	EMERGENCY	0	0	0	0	0	21.00
22.00	91.00	EMERGENCY	152,732	7,637	0	0	0	22.00
23.00	91.00	EMERGENCY	0	0	0	0	0	23.00
24.00	50.00	OPERATING ROOM	0	0	0	0	0	24.00
25.00	90.00	CLINIC	4,072	204	0	0	0	25.00
26.00	50.00	OPERATING ROOM	27,523	1,376	0	0	0	26.00
27.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	27.00
28.00	50.00	OPERATING ROOM	0	0	0	0	0	28.00
29.00	50.00	OPERATING ROOM	0	0	0	0	0	29.00
200.00			470,144	23,507	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	64,842	56,018	1,927,740		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	102,800	62,626	62,626		2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	2,209,149		3.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet A-8-2

Date/Time Prepared:
3/2/2015 11:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		4.00
5.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	9,984		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	8,681	8,148	8,148		6.00
7.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,225,430		7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	169,725		8.00
9.00	41.00	SUBPROVIDER - IRF	0	22,126	13,874	13,874		9.00
10.00	44.00	SKILLED NURSING FACILITY	0	845	805	805		10.00
11.00	50.00	OPERATING ROOM	0	8,144	13,056	13,056		11.00
12.00	60.00	LABORATORY	0	0	0	60,000		12.00
13.00	65.00	RESPIRATORY THERAPY	0	5,839	5,486	5,486		13.00
14.00	65.00	RESPIRATORY THERAPY	0	5,762	5,413	5,413		14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	0	5,916	3,709	3,709		15.00
16.00	69.00	ELECTROCARDIOLOGY	0	4,302	2,978	2,978		16.00
17.00	69.00	ELECTROCARDIOLOGY	0	10,464	7,386	7,386		17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	0	1,536	964	964		18.00
19.00	91.00	EMERGENCY	0	18,439	10,811	10,811		19.00
20.00	91.00	EMERGENCY	0	26,121	41,879	41,879		20.00
21.00	91.00	EMERGENCY	0	0	0	5,548,544		21.00
22.00	91.00	EMERGENCY	0	152,732	159,708	159,708		22.00
23.00	91.00	EMERGENCY	0	0	0	6,592		23.00
24.00	50.00	OPERATING ROOM	0	0	0	16,350		24.00
25.00	90.00	CLINIC	0	4,072	2,553	2,553		25.00
26.00	50.00	OPERATING ROOM	0	27,523	62,610	62,610		26.00
27.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	9,038,512		27.00
28.00	50.00	OPERATING ROOM	0	0	0	124,793		28.00
29.00	50.00	OPERATING ROOM	0	0	0	974,109		29.00
200.00			0	470,144	458,024	21,712,934		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B
Part I
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
	0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	0	0			1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING	27,446	0	27,446		1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT	316,460	0	0	316,460	1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT	3,160,301	0	0	0	3,160,301 1.03
1.04 00104	CAP REL COSTS-14TH STREET	256,645	0	0	0	0 1.04
1.05 00105	CAP REL COSTS-MOB PHASE I	26,130	0	0	0	0 1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP	11,761,424				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	17,401,196	0	0	14,213	163,174 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	39,398,881	0	0	76,276	578,255 5.00
6.00 00600	MAINTENANCE & REPAIRS	6,221,657	0	5,781	44,887	404,347 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,061,587	0	0	4,307	0 8.00
9.00 00900	HOUSEKEEPING	2,224,180	0	0	9,596	2,595 9.00
10.00 01000	DIETARY	644,206	0	0	0	82,151 10.00
11.00 01100	CAFETERIA	2,746,537	0	0	0	24,201 11.00
13.00 01300	NURSING ADMINISTRATION	5,638,283	0	0	7,045	0 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,655,905	0	0	1,203	49,890 16.00
20.00 02000	NURSING SCHOOL	2,202,599	0	21,665	0	147,583 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,073,675	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,172,765	0	0	0	0 22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0 23.00
23.01 02301	PARAMED PRGM-RADIOLOGY	189,348	0	0	0	3,639 23.01
23.02 02302	PARAMED PRGM-LABORATORY	43,857	0	0	1,249	0 23.02
23.03 02303	PARAMED PRGM-PHARMACY	84,103	0	0	0	0 23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	15,492,256	0	0	16,433	565,201 30.00
31.00 03100	INTENSIVE CARE UNIT	3,225,072	0	0	25,382	84,429 31.00
40.00 04000	SUBPROVIDER - IPF	4,125,627	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - IRF	1,561,103	0	0	2,109	39,024 41.00
43.00 04300	NURSERY	418,956	0	0	0	19,505 43.00
44.00 04400	SKILLED NURSING FACILITY	1,504,656	0	0	0	54,763 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,390,948	0	0	27,191	180,084 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,611,607	0	0	10,192	7,341 52.00
53.00 05300	ANESTHESIOLOGY	493,173	0	0	1,520	4,781 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,485,132	0	0	0	237,689 54.00
60.00 06000	LABORATORY	5,568,932	0	0	0	84,020 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,207,579	0	0	932	0 62.00
65.00 06500	RESPIRATORY THERAPY	2,196,296	0	0	4,040	0 65.00
66.00 06600	PHYSICAL THERAPY	1,361,983	0	0	5,299	37,500 66.00
67.00 06700	OCCUPATIONAL THERAPY	519,684	0	0	3,975	0 67.00
68.00 06800	SPEECH PATHOLOGY	264,030	0	0	1,346	0 68.00
69.00 06900	ELECTROCARDIOLOGY	2,297,175	0	0	20,824	41,463 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	297,504	0	0	5,292	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,231,713	0	0	0	27,233 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	10,110,724	0	0	0	46,209 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	13,517,595	0	0	780	27,346 73.00
74.00 07400	RENAL DIALYSIS	410,714	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	914,876	0	0	0	0 88.00
90.00 09000	CLINIC	401,634	0	0	0	0 90.00
91.00 09100	EMERGENCY	4,613,284	0	0	19,355	125,455 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	5,336,143	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	2,181,120	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	205,046,701	0	27,446	303,446	3,037,878 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,722	2,799 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,519,747	0	0	0	0 192.00
192.01 19201	FASTCARE	529,080	0	0	0	0 192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.02 19302	DENMAN SERVICES	0	0	0	0	7,052 193.02
193.03 19303	MEALS ON WHEELS	0	0	0	0	0 193.03
193.04 19304	UNUSED SPACE	0	0	0	2,266	1,573 193.04
193.05 19305	HEALTH EDUCATION	14,820	0	0	0	0 193.05
193.06 19306	RENTED SPACE	0	0	0	1,026	110,999 193.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT		
		0	1.00	1.01	1.02	1.03		
193.07	19307	AUGUSTA PHARMACY	808,247	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	209,918,595	0	27,446	316,460	3,160,301	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	4A
	14TH STREET	MOB PHASE I	MVBLE EQUIP			
	1.04	1.05	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET	256,645				1.04
1.05 00105	CAP REL COSTS-MOB PHASE I	0	26,130			1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP			11,761,424		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	448	0	128,320	17,707,351	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	65,389	5,330	4,381,724	2,112,998	5.00
6.00 00600	MAINTENANCE & REPAIRS	60,499	0	244,235	449,875	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	373	0	4,051	11,604	8.00
9.00 00900	HOUSEKEEPING	2,611	0	95,732	395,335	9.00
10.00 01000	DIETARY	3,951	0	104,165	113,884	10.00
11.00 01100	CAFETERIA	5,080	0	0	309,988	11.00
13.00 01300	NURSING ADMINISTRATION	2,059	0	782,013	923,732	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,124	0	297,815	372,137	16.00
20.00 02000	NURSING SCHOOL	7,829	0	16,228	757,172	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	201,457	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	18	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	46,264	23.01
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	0	11,778	23.02
23.03 02303	PARAMED ED PRGM-PHARMACY	0	0	0	14,233	23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	188,552	2,523,021	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	73,390	592,791	31.00
40.00 04000	SUBPROVIDER - I/PF	23,864	0	16,050	751,457	40.00
41.00 04100	SUBPROVIDER - I/RF	0	0	26,032	271,106	41.00
43.00 04300	NURSERY	0	0	13,350	72,001	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	1,469	262,445	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	15,470	1,715,230	1,331,381	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	34,008	211,798	52.00
53.00 05300	ANESTHESIOLOGY	0	0	176,022	35,319	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	5,330	2,057,197	928,270	54.00
60.00 06000	LABORATORY	333	0	254,775	544,704	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	20,927	62.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	369,995	65.00
66.00 06600	PHYSICAL THERAPY	0	0	7,705	254,917	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	2,915	96,474	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	3,624	47,840	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	591,479	298,864	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	34,443	52,096	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,953	0	37,646	47,090	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	8,405	0	63,879	79,906	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	325	0	257,893	608,981	73.00
74.00 07400	RENAL DIALYSIS	0	0	3,809	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	78,880	88.00
90.00 09000	CLINIC	0	0	0	52,621	90.00
91.00 09100	EMERGENCY	7,953	0	82,652	714,063	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	4,888	0	10,387	713,214	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	0	48,879	297,549	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	200,084	26,130	11,755,687	16,978,167	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,117	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	20,036	0	787	616,026	192.00
192.01 19201	FASTCARE	0	0	4,664	77,587	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.02 19302	DENMAN SERVICES	1,886	0	286	0	193.02
193.03 19303	MEALS ON WHEELS	0	0	0	0	193.03
193.04 19304	UNUSED SPACE	22,362	0	0	0	193.04
193.05 19305	HEALTH EDUCATION	0	0	0	2,781	193.05
193.06 19306	RENTED SPACE	9,160	0	0	0	193.06
193.07 19307	AUGUSTA PHARMACY	0	0	0	32,790	193.07
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
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Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		14TH STREET	MOB PHASE I	MVBLE EQUIP			
		1.04	1.05	2.00			
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	256,645	26,130	11,761,424	17,707,351	209,918,595	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	6.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03	
1.04	00104	CAP REL COSTS-14TH STREET					1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I					1.05	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	46,618,853				5.00	
6.00	00600	MAINTENANCE & REPAIRS	2,121,482	9,552,763			6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	308,867	40,040	1,430,829		8.00	
9.00	00900	HOUSEKEEPING	779,374	129,372	3,242	3,642,037	9.00	
10.00	01000	DIETARY	270,737	290,423	12,051	45,496	1,567,064	10.00
11.00	01100	CAFETERIA	880,936	158,877	0	116,688	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,099,172	92,621	0	52,414	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	964,373	161,738	0	39,355	0	16.00
20.00	02000	NURSING SCHOOL	900,140	801,483	0	104,405	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	364,025	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	620,286	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	68,301	9,587	0	2,153	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	16,239	9,587	0	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	28,073	0	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,362,920	1,615,340	511,867	921,714	859,014	30.00
31.00	03100	INTENSIVE CARE UNIT	1,142,224	417,268	90,640	264,860	110,105	31.00
40.00	04000	SUBPROVIDER - IPF	1,403,705	446,755	66,850	238,565	327,664	40.00
41.00	04100	SUBPROVIDER - IRF	542,233	119,004	51,741	92,581	128,468	41.00
43.00	04300	NURSERY	149,538	51,392	8,240	24,389	0	43.00
44.00	04400	SKILLED NURSING FACILITY	520,525	144,292	42,189	86,369	141,813	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,185,224	794,274	184,100	438,410	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	535,260	97,563	37,541	96,711	0	52.00
53.00	05300	ANESTHESIOLOGY	202,923	24,265	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,058,524	664,549	126,901	177,009	0	54.00
60.00	06000	LABORATORY	1,842,135	227,623	296	65,262	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	350,980	7,153	0	1,059	0	62.00
65.00	06500	RESPIRATORY THERAPY	733,778	31,010	719	72,639	0	65.00
66.00	06600	PHYSICAL THERAPY	476,010	139,480	83	56,791	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	177,868	30,508	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	90,451	10,330	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	927,754	269,075	41,917	27,672	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111,147	40,616	4,444	13,236	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,097,888	164,488	7,021	24,425	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,943,048	279,108	11,914	41,437	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,114,600	84,111	0	32,155	0	73.00
74.00	07400	RENAL DIALYSIS	118,338	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	283,697	0	0	635	0	88.00
90.00	09000	CLINIC	129,681	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,588,057	627,983	220,432	324,439	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,731,331	91,506	0	129,995	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	721,564	0	3,579	22,872	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,963,408	8,071,421	1,425,767	3,513,736	1,567,064	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,464	140,353	5,062	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,186,625	375,092	0	0	0	192.00
192.01	19201	FASTCARE	174,523	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	2,633	53,882	0	22,025	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	7,480	440,177	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	5,025	0	0	0	0	193.05
193.06	19306	RENTED SPACE	34,596	471,838	0	106,276	0	193.06
193.07	19307	AUGUSTA PHARMACY	240,099	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	46,618,853	9,552,763	1,430,829	3,642,037	1,567,064	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES	
	11.00	13.00	16.00	20.00	21.00		
GENERAL SERVICE COST CENTERS							
1.00 00100							1.00
1.01 00101							1.01
1.02 00102							1.02
1.03 00103							1.03
1.04 00104							1.04
1.05 00105							1.05
2.00 00200							2.00
4.00 00400							4.00
5.00 00500							5.00
6.00 00600							6.00
8.00 00800							8.00
9.00 00900							9.00
10.00 01000							10.00
11.00 01100	4,242,307						11.00
13.00 01300	278,669	9,876,008					13.00
16.00 01600	167,011		4,710,551				16.00
20.00 02000	223,938			5,183,042			20.00
21.00 02100	0	0	0	0	1,639,157		21.00
22.00 02200	58,263	0	0	0	0		22.00
23.00 02300	0	0	0	0	0		23.00
23.01 02301	12,143	0	0	0	0		23.01
23.02 02302	3,276	0	0	0	0		23.02
23.03 02303	3,605	0	0	0	0		23.03
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	810,185	3,297,315	2,560,802	3,064,372	1,148,168		30.00
31.00 03100	169,500	689,836	328,214	211,048	89,471		31.00
40.00 04000	263,470	1,072,265	976,798	316,337	32,328		40.00
41.00 04100	85,789	349,145	382,991	0	52,210		41.00
43.00 04300	18,064	73,515	11,397	59,490	34,832		43.00
44.00 04400	94,683	385,361	422,736	334,908	0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	418,493	1,703,215	0	218,918	82,034		50.00
52.00 05200	60,496	246,223	0	174,064	0		52.00
53.00 05300	14,220	57,869	0	0	7,437		53.00
54.00 05400	269,765	0	0	0	24,891		54.00
60.00 06000	207,073	0	0	0	2,504		60.00
62.00 06200	6,305	0	0	0	0		62.00
65.00 06500	115,025	0	0	0	0		65.00
66.00 06600	55,985	0	0	0	0		66.00
67.00 06700	24,524	0	0	0	0		67.00
68.00 06800	11,054	0	0	0	0		68.00
69.00 06900	83,190	0	0	9,443	40,979		69.00
70.00 07000	20,287	0	0	0	8,727		70.00
71.00 07100	25,906	0	0	0	0		71.00
72.00 07200	43,960	0	0	0	0		72.00
73.00 07300	137,866	0	0	0	0		73.00
74.00 07400	0	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	0	0	0	0	0		88.00
90.00 09000	14,312	0	0	87,819	0		90.00
91.00 09100	215,053	875,223	27,613	123,230	115,576		91.00
92.00 09200							92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	174,332	709,508	0	541,707	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300							113.00
116.00 11600	90,995	370,343	0	41,706	0		116.00
118.00	4,177,437	9,829,818	4,710,551	5,183,042	1,639,157		118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	0	0	0	0	0		190.00
192.00 19200	63,982	0	0	0	0		192.00
192.01 19201	0	46,190	0	0	0		192.01
193.00 19300	0	0	0	0	0		193.00
193.02 19302	0	0	0	0	0		193.02
193.03 19303	0	0	0	0	0		193.03
193.04 19304	0	0	0	0	0		193.04
193.05 19305	888	0	0	0	0		193.05
193.06 19306	0	0	0	0	0		193.06
193.07 19307	0	0	0	0	0		193.07
200.00				0			200.00

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	
		11.00	13.00	16.00	20.00	21.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,242,307	9,876,008	4,710,551	5,183,042	1,639,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part I Date/Time Prepared: 3/2/2015 11:13 am
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Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	PARAMED PRGM-PHARMACY	
	SERVICES-OTHER PRGM COSTS					
	22.00					
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,851,332				22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0			23.00
23.01 02301	PARAMED PRGM-RADIOLOGY	0	0	331,435		23.01
23.02 02302	PARAMED PRGM-LABORATORY	0	0	0	85,986	23.02
23.03 02303	PARAMED PRGM-PHARMACY	0	0	0	0	130,014
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,997,252	0	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	155,635	0	0	0	31.00
40.00 04000	SUBPROVIDER - IPF	56,235	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	90,820	0	0	0	41.00
43.00 04300	NURSERY	60,591	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	142,699	0	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	12,937	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	43,298	0	331,435	0	54.00
60.00 06000	LABORATORY	4,356	0	0	85,986	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	71,283	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	15,181	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	130,014
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	201,045	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,851,332	0	331,435	85,986	130,014
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	FASTCARE	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.02 19302	DENMAN SERVICES	0	0	0	0	193.02
193.03 19303	MEALS ON WHEELS	0	0	0	0	193.03
193.04 19304	UNUSED SPACE	0	0	0	0	193.04
193.05 19305	HEALTH EDUCATION	0	0	0	0	193.05
193.06 19306	RENTED SPACE	0	0	0	0	193.06
193.07 19307	AUGUSTA PHARMACY	0	0	0	0	193.07
200.00	Cross Foot Adjustments	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B
Part I
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Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	
		SERVICES-OTHER PRGM COSTS					
		22.00	23.00	23.01	23.02	23.03	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,851,332	0	331,435	85,986	130,014	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING				1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT				1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT				1.03
1.04	00104	CAP REL COSTS-14TH STREET				1.04
1.05	00105	CAP REL COSTS-MOB PHASE I				1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				23.01
23.02	02302	PARAMED ED PRGM-LABORATORY				23.02
23.03	02303	PARAMED ED PRGM-PHARMACY				23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,934,412	-3,145,420	37,788,992	30.00
31.00	03100	INTENSIVE CARE UNIT	7,669,865	-245,106	7,424,759	31.00
40.00	04000	SUBPROVIDER - I PF	10,117,970	-88,563	10,029,407	40.00
41.00	04100	SUBPROVIDER - IRF	3,794,356	-143,030	3,651,326	41.00
43.00	04300	NURSERY	1,015,260	-95,423	919,837	43.00
44.00	04400	SKILLED NURSING FACILITY	3,996,209	0	3,996,209	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,827,671	-224,733	22,602,938	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,122,804	0	3,122,804	52.00
53.00	05300	ANESTHESIOLOGY	1,030,466	-20,374	1,010,092	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,409,990	-68,189	15,341,801	54.00
60.00	06000	LABORATORY	8,887,999	-6,860	8,881,139	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,594,935	0	1,594,935	62.00
65.00	06500	RESPIRATORY THERAPY	3,523,502	0	3,523,502	65.00
66.00	06600	PHYSICAL THERAPY	2,395,753	0	2,395,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	855,948	0	855,948	67.00
68.00	06800	SPEECH PATHOLOGY	428,675	0	428,675	68.00
69.00	06900	ELECTROCARDIOLOGY	4,721,118	-112,262	4,608,856	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	602,973	-23,908	579,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,668,363	0	9,668,363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,628,590	0	13,628,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,911,666	0	18,911,666	73.00
74.00	07400	RENAL DIALYSIS	532,861	0	532,861	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,278,088	0	1,278,088	88.00
90.00	09000	CLINIC	686,067	0	686,067	90.00
91.00	09100	EMERGENCY	9,881,413	-316,621	9,564,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	9,443,011	0	9,443,011	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	3,778,607	0	3,778,607	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	200,738,572	-4,490,489	196,248,083	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	165,517	0	165,517	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,782,295	0	5,782,295	192.00
192.01	19201	FASTCARE	832,044	0	832,044	192.01
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.02	19302	DENMAN SERVICES	87,764	0	87,764	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	193.03
193.04	19304	UNUSED SPACE	473,858	0	473,858	193.04
193.05	19305	HEALTH EDUCATION	23,514	0	23,514	193.05
193.06	19306	RENTED SPACE	733,895	0	733,895	193.06
193.07	19307	AUGUSTA PHARMACY	1,081,136	0	1,081,136	193.07
200.00		Cross Foot Adjustments	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	209,918,595	-4,490,489	205,428,106		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT		
			0	1.00	1.01	1.02		1.03
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03	
1.04	00104	CAP REL COSTS-14TH STREET					1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I					1.05	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,129	0	0	14,213	163,174	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	257,911	0	0	76,276	578,255	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,082	0	5,781	44,887	404,347	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	4,307	0	8.00
9.00	00900	HOUSEKEEPING	572	0	0	9,596	2,595	9.00
10.00	01000	DIETARY	0	0	0	0	82,151	10.00
11.00	01100	CAFETERIA	0	0	0	0	24,201	11.00
13.00	01300	NURSING ADMINISTRATION	20,548	0	0	7,045	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,563	0	0	1,203	49,890	16.00
20.00	02000	NURSING SCHOOL	5,151	0	21,665	0	147,583	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	829	0	0	0	3,639	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	1,249	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	76,102	0	0	16,433	565,201	30.00
31.00	03100	INTENSIVE CARE UNIT	21,992	0	0	25,382	84,429	31.00
40.00	04000	SUBPROVIDER - I PF	2,781	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	3,316	0	0	2,109	39,024	41.00
43.00	04300	NURSERY	0	0	0	0	19,505	43.00
44.00	04400	SKILLED NURSING FACILITY	18,764	0	0	0	54,763	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	983,787	0	0	27,191	180,084	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,192	7,341	52.00
53.00	05300	ANESTHESIOLOGY	14,466	0	0	1,520	4,781	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	439,312	0	0	0	237,689	54.00
60.00	06000	LABORATORY	149,389	0	0	0	84,020	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	932	0	62.00
65.00	06500	RESPIRATORY THERAPY	81,631	0	0	4,040	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,299	37,500	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,975	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,346	0	68.00
69.00	06900	ELECTROCARDIOLOGY	42,203	0	0	20,824	41,463	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,315	0	0	5,292	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,399	0	0	0	27,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,036	0	0	0	46,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	780	27,346	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	33,003	0	0	0	0	88.00
90.00	09000	CLINIC	65,271	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,152	0	0	19,355	125,455	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,559	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	143,748	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,534,011	0	27,446	303,446	3,037,878	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,722	2,799	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,268	0	0	0	0	192.00
192.01	19201	FASTCARE	73,183	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	0	0	7,052	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	2,266	1,573	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	0	1,026	110,999	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140015		Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 3/2/2015 11:13 am	
		CAPITAL RELATED COSTS					
Cost Center Description		Directly Assigned New Capital Related Costs	BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
			1.00	1.01	1.02	1.03	
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,652,462	0	27,446	316,460	3,160,301	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
		14TH STREET	MOB PHASE I	MVBLE EQUIP				
		1.04	1.05	2.00				2A
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03	
1.04	00104	CAP REL COSTS-14TH STREET					1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I					1.05	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	448	0	128,320	312,284	312,284	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	65,389	5,330	4,381,724	5,364,885	37,264	5.00
6.00	00600	MAINTENANCE & REPAIRS	60,499	0	244,235	760,831	7,934	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	373	0	4,051	8,731	205	8.00
9.00	00900	HOUSEKEEPING	2,611	0	95,732	111,106	6,972	9.00
10.00	01000	DIETARY	3,951	0	104,165	190,267	2,008	10.00
11.00	01100	CAFETERIA	5,080	0	0	29,281	5,467	11.00
13.00	01300	NURSING ADMINISTRATION	2,059	0	782,013	811,665	16,290	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,124	0	297,815	354,595	6,563	16.00
20.00	02000	NURSING SCHOOL	7,829	0	16,228	198,456	13,353	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	3,553	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	18	18	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	4,468	816	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	1,249	208	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	251	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	188,552	846,288	44,501	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	73,390	205,193	10,454	31.00
40.00	04000	SUBPROVIDER - IPF	23,864	0	16,050	42,695	13,252	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	26,032	70,481	4,781	41.00
43.00	04300	NURSERY	0	0	13,350	32,855	1,270	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,469	74,996	4,628	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,470	1,715,230	2,921,762	23,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	34,008	51,541	3,735	52.00
53.00	05300	ANESTHESIOLOGY	0	0	176,022	196,789	623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,330	2,057,197	2,739,528	16,370	54.00
60.00	06000	LABORATORY	333	0	254,775	488,517	9,606	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	932	369	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	85,671	6,525	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,705	50,504	4,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,915	6,890	1,701	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,624	4,970	844	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	591,479	695,969	5,271	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	34,443	73,050	919	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,953	0	37,646	115,231	830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,405	0	63,879	195,529	1,409	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	325	0	257,893	286,344	10,740	73.00
74.00	07400	RENAL DIALYSIS	0	0	3,809	3,809	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	33,003	1,391	88.00
90.00	09000	CLINIC	0	0	0	65,271	928	90.00
91.00	09100	EMERGENCY	7,953	0	82,652	237,567	12,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,888	0	10,387	18,834	12,578	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	48,879	192,627	5,247	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	200,084	26,130	11,755,687	17,884,682	299,425	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,117	0	0	15,638	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,036	0	787	66,091	10,864	192.00
192.01	19201	FASTCARE	0	0	4,664	77,847	1,368	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	1,886	0	286	9,224	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	22,362	0	0	26,201	0	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	49	193.05
193.06	19306	RENTED SPACE	9,160	0	0	121,185	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	578	193.07
200.00		Cross Foot Adjustments				0		200.00

ALLOCATION OF CAPITAL RELATED COSTS		CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		14TH STREET	MOB PHASE I	MVBLE EQUIP			
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	256,645	26,130	11,761,424	18,200,868	312,284	202.00

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B
Part II
Date/Time Prepared:
3/2/2015 11:13 am

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared: 3/2/2015 11:13 am			
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING				1.01	
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT				1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT				1.03	
1.04	00104	CAP REL COSTS-14TH STREET				1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I				1.05	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	5,402,149			5.00	
6.00	00600	MAINTENANCE & REPAIRS	245,834	1,014,599		6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	35,791	4,253	48,980	8.00	
9.00	00900	HOUSEKEEPING	90,313	13,741	111	222,243	
10.00	01000	DIETARY	31,373	30,846	413	2,776	257,683
11.00	01100	CAFETERIA	102,082	16,874	0	7,120	0
13.00	01300	NURSING ADMINISTRATION	243,249	9,837	0	3,198	0
16.00	01600	MEDICAL RECORDS & LIBRARY	111,750	17,178	0	2,401	0
20.00	02000	NURSING SCHOOL	104,307	85,125	0	6,371	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	42,183	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	71,878	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	7,915	1,018	0	131	0
23.02	02302	PARAMED ED PRGM-LABORATORY	1,882	1,018	0	0	0
23.03	02303	PARAMED ED PRGM-PHARMACY	3,253	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	621,473	171,568	17,522	56,248	141,254
31.00	03100	INTENSIVE CARE UNIT	132,359	44,318	3,103	16,162	18,105
40.00	04000	SUBPROVIDER - IPF	162,659	47,450	2,288	14,558	53,880
41.00	04100	SUBPROVIDER - IRF	62,833	12,639	1,771	5,649	21,125
43.00	04300	NURSERY	17,328	5,458	282	1,488	0
44.00	04400	SKILLED NURSING FACILITY	60,318	15,325	1,444	5,270	23,319
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	484,978	84,360	6,302	26,752	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	62,025	10,362	1,285	5,901	0
53.00	05300	ANESTHESIOLOGY	23,514	2,577	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	354,417	70,582	4,344	10,801	0
60.00	06000	LABORATORY	213,464	24,176	10	3,982	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	40,671	760	0	65	0
65.00	06500	RESPIRATORY THERAPY	85,029	3,294	25	4,433	0
66.00	06600	PHYSICAL THERAPY	55,159	14,814	3	3,465	0
67.00	06700	OCCUPATIONAL THERAPY	20,611	3,240	0	0	0
68.00	06800	SPEECH PATHOLOGY	10,481	1,097	0	0	0
69.00	06900	ELECTROCARDIOLOGY	107,507	28,578	1,435	1,689	0
70.00	07000	ELECTROENCEPHALOGRAPHY	12,880	4,314	152	808	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	243,100	17,470	240	1,490	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	341,036	29,644	408	2,529	0
73.00	07300	DRUGS CHARGED TO PATIENTS	476,794	8,933	0	1,962	0
74.00	07400	RENAL DIALYSIS	13,713	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	32,874	0	0	39	0
90.00	09000	CLINIC	15,027	0	0	0	0
91.00	09100	EMERGENCY	184,022	66,698	7,546	19,798	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	200,624	9,719	0	7,932	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	83,614	0	123	1,396	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,210,320	857,266	48,807	214,414	257,683
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	517	14,907	173	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	137,504	39,838	0	0	0
192.01	19201	FASTCARE	20,223	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	DENMAN SERVICES	305	5,723	0	1,344	0
193.03	19303	MEALS ON WHEELS	0	0	0	0	0
193.04	19304	UNUSED SPACE	867	46,751	0	0	0
193.05	19305	HEALTH EDUCATION	582	0	0	0	0
193.06	19306	RENTED SPACE	4,009	50,114	0	6,485	0
193.07	19307	AUGUSTA PHARMACY	27,822	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	5,402,149	1,014,599	48,980	222,243	257,683

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared: 3/2/2015 11:13 am		
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES
		11.00	13.00	16.00	20.00	21.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
1.01	00101					1.01
1.02	00102					1.02
1.03	00103					1.03
1.04	00104					1.04
1.05	00105					1.05
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	160,824				11.00
13.00	01300	10,564	1,094,803			13.00
16.00	01600	6,331		498,818		16.00
20.00	02000	8,489			416,101	20.00
21.00	02100					45,736
21.00	02100					21.00
22.00	02200	2,209				22.00
23.00	02300					23.00
23.01	02301	460				23.01
23.02	02302	124				23.02
23.03	02303	137				23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	30,712	365,524	271,173		30.00
31.00	03100	6,426	76,472	34,756		31.00
40.00	04000	9,988	118,866	103,437		40.00
41.00	04100	3,252	38,704	40,556		41.00
43.00	04300	685	8,149	1,207		43.00
44.00	04400	3,589	42,719	44,765		44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	15,865	188,810	0		50.00
52.00	05200	2,293	27,295	0		52.00
53.00	05300	539	6,415	0		53.00
54.00	05400	10,227	0	0		54.00
60.00	06000	7,850	0	0		60.00
62.00	06200	239	0	0		62.00
65.00	06500	4,361	0	0		65.00
66.00	06600	2,122	0	0		66.00
67.00	06700	930	0	0		67.00
68.00	06800	419	0	0		68.00
69.00	06900	3,154	0	0		69.00
70.00	07000	769	0	0		70.00
71.00	07100	982	0	0		71.00
72.00	07200	1,667	0	0		72.00
73.00	07300	5,226	0	0		73.00
74.00	07400	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0		88.00
90.00	09000	543	0	0		90.00
91.00	09100	8,153	97,023	2,924		91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	6,609	78,652	0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
116.00	11600	3,450	41,054	0		116.00
118.00		158,364	1,089,683	498,818	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0		190.00
192.00	19200	2,426	0	0		192.00
192.01	19201	0	5,120	0		192.01
193.00	19300	0	0	0		193.00
193.02	19302	0	0	0		193.02
193.03	19303	0	0	0		193.03
193.04	19304	0	0	0		193.04
193.05	19305	34	0	0		193.05
193.06	19306	0	0	0		193.06
193.07	19307	0	0	0		193.07
200.00					416,101	45,736
Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140015			Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 3/2/2015 11:13 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES	
		11.00	13.00	16.00	20.00	21.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	160,824	1,094,803	498,818	416,101	45,736		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared: 3/2/2015 11:13 am
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Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	PARAMED PRGM-PHARMACY	
	SERVICES-OTHER PRGM COSTS					
	22.00					
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	74,105	0			22.00
23.00 02300	PARAMED PRGM-(SPECIFY)		0			23.00
23.01 02301	PARAMED PRGM-RADIOLOGY			14,808		23.01
23.02 02302	PARAMED PRGM-LABORATORY				4,481	23.02
23.03 02303	PARAMED PRGM-PHARMACY					3,641
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS					30.00
31.00 03100	INTENSIVE CARE UNIT					31.00
40.00 04000	SUBPROVIDER - IPF					40.00
41.00 04100	SUBPROVIDER - IRF					41.00
43.00 04300	NURSERY					43.00
44.00 04400	SKILLED NURSING FACILITY					44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM					50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM					52.00
53.00 05300	ANESTHESIOLOGY					53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC					54.00
60.00 06000	LABORATORY					60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS					62.00
65.00 06500	RESPIRATORY THERAPY					65.00
66.00 06600	PHYSICAL THERAPY					66.00
67.00 06700	OCCUPATIONAL THERAPY					67.00
68.00 06800	SPEECH PATHOLOGY					68.00
69.00 06900	ELECTROCARDIOLOGY					69.00
70.00 07000	ELECTROENCEPHALOGRAPHY					70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS					71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS					72.00
73.00 07300	DRUGS CHARGED TO PATIENTS					73.00
74.00 07400	RENAL DIALYSIS					74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC					88.00
90.00 09000	CLINIC					90.00
91.00 09100	EMERGENCY					91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE					116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES					192.00
192.01 19201	FASTCARE					192.01
193.00 19300	NONPAID WORKERS					193.00
193.02 19302	DENMAN SERVICES					193.02
193.03 19303	MEALS ON WHEELS					193.03
193.04 19304	UNUSED SPACE					193.04
193.05 19305	HEALTH EDUCATION					193.05
193.06 19306	RENTED SPACE					193.06
193.07 19307	AUGUSTA PHARMACY					193.07
200.00	Cross Foot Adjustments	74,105	0	14,808	4,481	3,641

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

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Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	
		SERVICES-OTHER PRGM COSTS					
		22.00	23.00	23.01	23.02	23.03	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	74,105	0	14,808	4,481	3,641	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING				1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT				1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT				1.03
1.04	00104	CAP REL COSTS-14TH STREET				1.04
1.05	00105	CAP REL COSTS-MOB PHASE I				1.05
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				23.01
23.02	02302	PARAMED ED PRGM-LABORATORY				23.02
23.03	02303	PARAMED ED PRGM-PHARMACY				23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,566,263	0	2,566,263	30.00
31.00	03100	INTENSIVE CARE UNIT	547,348	0	547,348	31.00
40.00	04000	SUBPROVIDER - IPF	569,073	0	569,073	40.00
41.00	04100	SUBPROVIDER - IRF	261,791	0	261,791	41.00
43.00	04300	NURSERY	68,722	0	68,722	43.00
44.00	04400	SKILLED NURSING FACILITY	276,373	0	276,373	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,752,309	0	3,752,309	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	164,437	0	164,437	52.00
53.00	05300	ANESTHESIOLOGY	230,457	0	230,457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,206,269	0	3,206,269	54.00
60.00	06000	LABORATORY	747,605	0	747,605	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	43,036	0	43,036	62.00
65.00	06500	RESPIRATORY THERAPY	189,338	0	189,338	65.00
66.00	06600	PHYSICAL THERAPY	130,563	0	130,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,372	0	33,372	67.00
68.00	06800	SPEECH PATHOLOGY	17,811	0	17,811	68.00
69.00	06900	ELECTROCARDIOLOGY	843,603	0	843,603	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,892	0	92,892	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	379,343	0	379,343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	572,222	0	572,222	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	789,999	0	789,999	73.00
74.00	07400	RENAL DIALYSIS	17,522	0	17,522	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,307	0	67,307	88.00
90.00	09000	CLINIC	81,769	0	81,769	90.00
91.00	09100	EMERGENCY	636,324	0	636,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	334,948	0	334,948	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	327,511	0	327,511	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,948,207	0	16,948,207	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,235	0	31,235	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	256,723	0	256,723	192.00
192.01	19201	FASTCARE	104,558	0	104,558	192.01
193.00	19300	NONPAID WORKERS	0	0	0	193.00
193.02	19302	DENMAN SERVICES	16,596	0	16,596	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	193.03
193.04	19304	UNUSED SPACE	73,819	0	73,819	193.04
193.05	19305	HEALTH EDUCATION	665	0	665	193.05
193.06	19306	RENTED SPACE	181,793	0	181,793	193.06
193.07	19307	AUGUSTA PHARMACY	28,400	0	28,400	193.07
200.00		Cross Foot Adjustments	558,872	0	558,872	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B
Part II
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	18,200,868	0	18,200,868		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1

Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)		
		1.00	1.01	1.02	1.03	1.04		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	0				1.00	
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	18,141			1.01	
1.02	00102	CAP REL COSTS-OLD BUILDING & FIXT	0		130,724		1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIXT	0	0	0	448,167	1.03	
1.04	00104	CAP REL COSTS-14TH STREET	0	0	0	258,594	1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I	0	0	0	0	1.05	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,871	23,140	451	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	31,509	82,003	65,885	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	3,821	18,542	57,341	60,958	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,779	0	376	8.00
9.00	00900	HOUSEKEEPING	0	0	3,964	368	2,631	9.00
10.00	01000	DIETARY	0	0	0	11,650	3,981	10.00
11.00	01100	CAFETERIA	0	0	0	3,432	5,119	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,910	0	2,075	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	497	7,075	1,133	16.00
20.00	02000	NURSING SCHOOL	0	14,320	0	20,929	7,888	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	516	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	6,788	80,152	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	10,485	11,973	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	24,045	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	871	5,534	0	41.00
43.00	04300	NURSERY	0	0	0	2,766	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	7,766	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	11,232	25,538	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	4,210	1,041	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,707	0	54.00
60.00	06000	LABORATORY	0	0	0	11,915	336	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	385	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,669	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,189	5,318	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,642	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	556	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,602	5,880	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,186	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,862	4,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,553	8,469	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	322	3,878	327	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	7,995	17,791	8,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	4,925	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,141	125,348	430,806	201,603	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,016	397	3,141	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	20,188	192.00
192.01	19201	FASTCARE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	0	1,000	1,900	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	936	223	22,532	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	424	15,741	9,230	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1

Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	27,446	316,460	3,160,301	256,645	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	1.512927	2.420826	7.051615	0.992463	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.05	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I	10,099				1.05
2.00 00200	CAP REL COSTS-MVBLE EQUIP		11,816,495			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	128,921	94,372,183		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,060	4,402,236	11,261,336	-46,618,853	163,299,742
6.00 00600	MAINTENANCE & REPAIRS	0	245,379	2,397,633	0	7,431,281
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,070	61,843	0	1,081,922
9.00 00900	HOUSEKEEPING	0	96,180	2,106,961	0	2,730,049
10.00 01000	DIETARY	0	104,653	606,950	0	948,357
11.00 01100	CAFETERIA	0	0	1,652,098	0	3,085,806
13.00 01300	NURSING ADMINISTRATION	0	785,675	4,923,079	0	7,353,132
16.00 01600	MEDICAL RECORDS & LIBRARY	0	299,210	1,983,326	0	3,378,074
20.00 02000	NURSING SCHOOL	0	16,304	4,035,390	0	3,153,076
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,073,675	0	1,275,132
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	18	0	0	2,172,783
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	246,565	0	239,251
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	62,769	0	56,884
23.03 02303	PARAMED ED PRGM-PHARMACY	0	0	75,858	0	98,336
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	189,435	13,446,497	0	18,785,463
31.00 03100	INTENSIVE CARE UNIT	0	73,734	3,159,312	0	4,001,064
40.00 04000	SUBPROVIDER - IPF	0	16,125	4,004,930	0	4,916,998
41.00 04100	SUBPROVIDER - IRF	0	26,154	1,444,874	0	1,899,374
43.00 04300	NURSERY	0	13,413	383,734	0	523,812
44.00 04400	SKILLED NURSING FACILITY	0	1,476	1,398,712	0	1,823,333
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,979	1,723,262	7,095,666	0	14,660,304
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	34,167	1,128,789	0	1,874,946
53.00 05300	ANESTHESIOLOGY	0	176,846	188,232	0	710,815
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,060	2,066,830	4,947,262	0	10,713,618
60.00 06000	LABORATORY	0	255,968	2,903,028	0	6,452,764
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	111,534	0	1,229,438
65.00 06500	RESPIRATORY THERAPY	0	0	1,971,909	0	2,570,331
66.00 06600	PHYSICAL THERAPY	0	7,741	1,358,591	0	1,667,404
67.00 06700	OCCUPATIONAL THERAPY	0	2,929	514,162	0	623,048
68.00 06800	SPEECH PATHOLOGY	0	3,641	254,965	0	316,840
69.00 06900	ELECTROCARDIOLOGY	0	594,249	1,592,809	0	3,249,805
70.00 07000	ELECTROENCEPHALOGRAPHY	0	34,604	277,648	0	389,335
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	37,822	250,970	0	7,348,635
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	64,178	425,863	0	10,309,123
73.00 07300	DRUGS CHARGED TO PATIENTS	0	259,101	3,245,596	0	14,412,920
74.00 07400	RENAL DIALYSIS	0	3,827	0	0	414,523
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	420,394	0	993,756
90.00 09000	CLINIC	0	0	280,449	0	454,255
91.00 09100	EMERGENCY	0	83,039	3,805,637	0	5,562,762
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	10,436	3,801,114	0	6,064,632
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
116.00 11600	HOSPICE	0	49,108	1,585,802	0	2,527,548
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,099	11,810,731	90,485,962	-46,618,853	157,500,929
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15,638
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	791	3,283,141	0	4,156,596
192.01 19201	FASTCARE	0	4,686	413,503	0	611,331
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.02 19302	DENMAN SERVICES	0	287	0	0	9,224
193.03 19303	MEALS ON WHEELS	0	0	0	0	0
193.04 19304	UNUSED SPACE	0	0	0	0	26,201
193.05 19305	HEALTH EDUCATION	0	0	14,820	0	17,601
193.06 19306	RENTED SPACE	0	0	0	0	121,185

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1

Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.05	2.00					4.00
193.07	19307	AUGUSTA PHARMACY	0	0	174,757	0	841,037	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	26,130	11,761,424	17,707,351		46,618,853	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.587385	0.995339	0.187633		0.285480	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			312,284		5,402,149	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003309		0.033081	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1

Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		MAINTENANCE & REPAIRS (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	514,144					6.00
8.00	00800	2,155	1,252,274				8.00
9.00	00900	6,963	2,837	103,186			9.00
10.00	01000						10.00
11.00	01100	15,631	10,547	1,289	180,837		11.00
13.00	01300	8,551	0	3,306	0	463,600	13.00
16.00	01600	4,985	0	1,485	0	30,453	16.00
20.00	02000	8,705	0	1,115	0	18,251	20.00
21.00	02100	43,137	0	2,958	0	24,472	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
23.01	02301	0	0	0	0	0	23.01
23.02	02302	516	0	61	0	1,327	23.02
23.03	02303	516	0	0	0	358	23.03
		0	0	0	0	394	23.03
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	86,940	447,992	26,114	99,129	88,537	30.00
31.00	03100	22,458	79,329	7,504	12,706	18,523	31.00
40.00	04000	24,045	58,508	6,759	37,812	28,792	40.00
41.00	04100	6,405	45,284	2,623	14,825	9,375	41.00
43.00	04300	2,766	7,212	691	0	1,974	43.00
44.00	04400	7,766	36,924	2,447	16,365	10,347	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	42,749	161,126	12,421	0	45,733	50.00
52.00	05200	5,251	32,856	2,740	0	6,611	52.00
53.00	05300	1,306	0	0	0	1,554	53.00
54.00	05400	35,767	111,065	5,015	0	29,480	54.00
60.00	06000	12,251	259	1,849	0	22,629	60.00
62.00	06200	385	0	30	0	689	62.00
65.00	06500	1,669	629	2,058	0	12,570	65.00
66.00	06600	7,507	73	1,609	0	6,118	66.00
67.00	06700	1,642	0	0	0	2,680	67.00
68.00	06800	556	0	0	0	1,208	68.00
69.00	06900	14,482	36,686	784	0	9,091	69.00
70.00	07000	2,186	3,889	375	0	2,217	70.00
71.00	07100	8,853	6,145	692	0	2,831	71.00
72.00	07200	15,022	10,427	1,174	0	4,804	72.00
73.00	07300	4,527	0	911	0	15,066	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	18	0	0	88.00
90.00	09000	0	0	0	0	1,564	90.00
91.00	09100	33,799	192,924	9,192	0	23,501	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	4,925	0	3,683	0	19,051	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	3,132	648	0	9,944	116.00
118.00		434,416	1,247,844	99,551	180,837	456,511	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	7,554	4,430	0	0	0	190.00
192.00	19200	20,188	0	0	0	6,992	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
193.02	19302	2,900	0	624	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	23,691	0	0	0	0	193.04
193.05	19305	0	0	0	0	97	193.05
193.06	19306	25,395	0	3,011	0	0	193.06
193.07	19307	0	0	0	0	0	193.07
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1

Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		MAINTENANCE & REPAIRS (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	9,552,763	1,430,829	3,642,037	1,567,064	4,242,307	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.579937	1.142585	35.295844	8.665616	9.150792	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,014,599	48,980	222,243	257,683	160,824	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.973375	0.039113	2.153810	1.424946	0.346903	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
				13.00	16.00		20.00
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01 00101	CAP REL COSTS-BUTLER BUILDING					1.01	
1.02 00102	CAP REL COSTS-OLD BUILDING & FIXT					1.02	
1.03 00103	CAP REL COSTS-NEW BUILDING & FIXT					1.03	
1.04 00104	CAP REL COSTS-14TH STREET					1.04	
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05	
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00 00500	ADMINISTRATIVE & GENERAL					5.00	
6.00 00600	MAINTENANCE & REPAIRS					6.00	
8.00 00800	LAUNDRY & LINEN SERVICE					8.00	
9.00 00900	HOUSEKEEPING					9.00	
10.00 01000	DIETARY					10.00	
11.00 01100	CAFETERIA					11.00	
13.00 01300	NURSING ADMINISTRATION	1,650,645				13.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	0	115,319			16.00	
20.00 02000	NURSING SCHOOL	0	0	32,933		20.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21,600	21.00	
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00	
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00	
23.01 02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	0	23.01	
23.02 02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	23.02	
23.03 02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	23.03	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	551,103	62,691	19,471	15,130	15,130	30.00
31.00 03100	INTENSIVE CARE UNIT	115,297	8,035	1,341	1,179	1,179	31.00
40.00 04000	SUBPROVIDER - IPF	179,215	23,913	2,010	426	426	40.00
41.00 04100	SUBPROVIDER - IRF	58,355	9,376	0	688	688	41.00
43.00 04300	NURSERY	12,287	279	378	459	459	43.00
44.00 04400	SKILLED NURSING FACILITY	64,408	10,349	2,128	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	284,670	0	1,391	1,081	1,081	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	41,153	0	1,106	0	0	52.00
53.00 05300	ANESTHESIOLOGY	9,672	0	0	98	98	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	328	328	54.00
60.00 06000	LABORATORY	0	0	0	33	33	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	60	540	540	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	115	115	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000	CLINIC	0	0	558	0	0	90.00
91.00 09100	EMERGENCY	146,282	676	783	1,523	1,523	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	118,585	0	3,442	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 11600	HOSPICE	61,898	0	265	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,642,925	115,319	32,933	21,600	21,600	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	FASTCARE	7,720	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02 19302	DENMAN SERVICES	0	0	0	0	0	193.02
193.03 19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04 19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05 19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06 19306	RENTED SPACE	0	0	0	0	0	193.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1

Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
				13.00	16.00	
193.07 19307 AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	9,876,008	4,710,551	5,183,042	1,639,157	2,851,332	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	5.983121	40.848004	157.381411	75.886898	132.006111	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1,094,803	498,818	416,101	45,736	74,105	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.663258	4.325549	12.634774	2.117407	3.430787	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1

Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		PARAMED PRGM (ASSIGNED TIME)	PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED PRGM-PHARMACY (ASSIGNED TIME)		
		23.00	23.01	23.02	23.03		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
1.05	00105						1.05
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
16.00	01600						16.00
20.00	02000						20.00
21.00	02100						21.00
22.00	02200						22.00
23.00	02300	0					23.00
23.01	02301	0	100				23.01
23.02	02302	0	0	100			23.02
23.03	02303	0	0	0	100		23.03
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	0	0		30.00
31.00	03100	0	0	0	0		31.00
40.00	04000	0	0	0	0		40.00
41.00	04100	0	0	0	0		41.00
43.00	04300	0	0	0	0		43.00
44.00	04400	0	0	0	0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0		50.00
52.00	05200	0	0	0	0		52.00
53.00	05300	0	0	0	0		53.00
54.00	05400	0	100	0	0		54.00
60.00	06000	0	0	100	0		60.00
62.00	06200	0	0	0	0		62.00
65.00	06500	0	0	0	0		65.00
66.00	06600	0	0	0	0		66.00
67.00	06700	0	0	0	0		67.00
68.00	06800	0	0	0	0		68.00
69.00	06900	0	0	0	0		69.00
70.00	07000	0	0	0	0		70.00
71.00	07100	0	0	0	0		71.00
72.00	07200	0	0	0	0		72.00
73.00	07300	0	0	0	100		73.00
74.00	07400	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0		88.00
90.00	09000	0	0	0	0		90.00
91.00	09100	0	0	0	0		91.00
92.00	09200	0	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0		116.00
118.00		0	100	100	100		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
192.00	19200	0	0	0	0		192.00
192.01	19201	0	0	0	0		192.01
193.00	19300	0	0	0	0		193.00
193.02	19302	0	0	0	0		193.02
193.03	19303	0	0	0	0		193.03
193.04	19304	0	0	0	0		193.04
193.05	19305	0	0	0	0		193.05
193.06	19306	0	0	0	0		193.06
193.07	19307	0	0	0	0		193.07
200.00							200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet B-1

Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)		
		23.00	23.01	23.02	23.03		
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	331,435	85,986	130,014		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	3,314.350000	859.860000	1,300.140000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	14,808	4,481	3,641		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	148.080000	44.810000	36.410000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs					
			Total Costs	RCE Disallowance	Total Costs			
	1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,788,992		37,788,992	8,148	37,797,140	30.00
31.00	03100	INTENSIVE CARE UNIT	7,424,759		7,424,759	0	7,424,759	31.00
40.00	04000	SUBPROVIDER - IPF	10,029,407		10,029,407	0	10,029,407	40.00
41.00	04100	SUBPROVIDER - IRF	3,651,326		3,651,326	13,874	3,665,200	41.00
43.00	04300	NURSERY	919,837		919,837	0	919,837	43.00
44.00	04400	SKILLED NURSING FACILITY	3,996,209		3,996,209	805	3,997,014	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,602,938		22,602,938	75,666	22,678,604	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,122,804		3,122,804	0	3,122,804	52.00
53.00	05300	ANESTHESIOLOGY	1,010,092		1,010,092	0	1,010,092	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,341,801		15,341,801	0	15,341,801	54.00
60.00	06000	LABORATORY	8,881,139		8,881,139	0	8,881,139	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,594,935		1,594,935	0	1,594,935	62.00
65.00	06500	RESPIRATORY THERAPY	3,523,502	0	3,523,502	10,899	3,534,401	65.00
66.00	06600	PHYSICAL THERAPY	2,395,753	0	2,395,753	0	2,395,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	855,948	0	855,948	0	855,948	67.00
68.00	06800	SPEECH PATHOLOGY	428,675	0	428,675	0	428,675	68.00
69.00	06900	ELECTROCARDIOLOGY	4,608,856		4,608,856	10,364	4,619,220	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	579,065		579,065	4,673	583,738	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,668,363		9,668,363	0	9,668,363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,628,590		13,628,590	0	13,628,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,911,666		18,911,666	0	18,911,666	73.00
74.00	07400	RENAL DIALYSIS	532,861		532,861	0	532,861	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,278,088		1,278,088	0	1,278,088	88.00
90.00	09000	CLINIC	686,067		686,067	2,553	688,620	90.00
91.00	09100	EMERGENCY	9,564,792		9,564,792	212,398	9,777,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,880,628		6,880,628		6,880,628	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	9,443,011		9,443,011		9,443,011	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,778,607		3,778,607		3,778,607	116.00
200.00		Subtotal (see instructions)	203,128,711	0	203,128,711	339,380	203,468,091	200.00
201.00		Less Observation Beds	6,880,628		6,880,628		6,880,628	201.00
202.00		Total (see instructions)	196,248,083	0	196,248,083	339,380	196,587,463	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 3/2/2015 11:13 am
		Title XVII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,339,059		56,339,059	30.00
31.00	03100	INTENSIVE CARE UNIT	27,083,875		27,083,875	31.00
40.00	04000	SUBPROVIDER - IPF	23,835,544		23,835,544	40.00
41.00	04100	SUBPROVIDER - IRF	5,230,883		5,230,883	41.00
43.00	04300	NURSERY	2,822,371		2,822,371	43.00
44.00	04400	SKILLED NURSING FACILITY	4,543,679		4,543,679	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,497,175	56,227,692	81,724,867	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,105,093	526,531	5,631,624	52.00
53.00	05300	ANESTHESIOLOGY	7,239,248	10,884,797	18,124,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,462,138	87,794,205	120,256,343	54.00
60.00	06000	LABORATORY	35,495,373	48,536,753	84,032,126	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,831,324	1,288,558	4,119,882	62.00
65.00	06500	RESPIRATORY THERAPY	8,403,207	2,981,768	11,384,975	65.00
66.00	06600	PHYSICAL THERAPY	3,603,580	374,365	3,977,945	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,046,729	55,593	2,102,322	67.00
68.00	06800	SPEECH PATHOLOGY	817,457	404,240	1,221,697	68.00
69.00	06900	ELECTROCARDIOLOGY	29,735,458	42,427,277	72,162,735	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	304,498	2,158,942	2,463,440	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,664,109	27,389,742	55,053,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,460,311	17,357,430	40,817,741	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,236,073	29,944,122	92,180,195	73.00
74.00	07400	RENAL DIALYSIS	1,041,511	77,798	1,119,309	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	701,154	701,154	88.00
90.00	09000	CLINIC	139	466,977	467,116	90.00
91.00	09100	EMERGENCY	9,670,165	26,678,213	36,348,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,500,994	16,787,573	19,288,567	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	7,453,302	7,453,302	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	23,227	3,706,169	3,729,396	116.00
200.00		Subtotal (see instructions)	399,993,220	384,223,201	784,216,421	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	399,993,220	384,223,201	784,216,421	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 3/2/2015 11:13 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.277499		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.554512		52.00
53.00	05300 ANESTHESIOLOGY	0.055732		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.127576		54.00
60.00	06000 LABORATORY	0.105687		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.387131		62.00
65.00	06500 RESPIRATORY THERAPY	0.310444		65.00
66.00	06600 PHYSICAL THERAPY	0.602259		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.407144		67.00
68.00	06800 SPEECH PATHOLOGY	0.350885		68.00
69.00	06900 ELECTROCARDIOLOGY	0.064011		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.236961		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175616		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.333889		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205160		73.00
74.00	07400 RENAL DIALYSIS	0.476062		74.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	1.474195		90.00
91.00	09100 EMERGENCY	0.268986		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.356721		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 3/2/2015 11:13 am			
			Title XIX	Hospital	Cost			
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs					
			Total Costs	RCE Disallowance	Total Costs			
	1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,788,992		37,788,992	8,148	37,797,140	30.00
31.00	03100	INTENSIVE CARE UNIT	7,424,759		7,424,759	0	7,424,759	31.00
40.00	04000	SUBPROVIDER - IPF	10,029,407		10,029,407	0	10,029,407	40.00
41.00	04100	SUBPROVIDER - IRF	3,651,326		3,651,326	13,874	3,665,200	41.00
43.00	04300	NURSERY	919,837		919,837	0	919,837	43.00
44.00	04400	SKILLED NURSING FACILITY	3,996,209		3,996,209	805	3,997,014	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,602,938		22,602,938	75,666	22,678,604	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,122,804		3,122,804	0	3,122,804	52.00
53.00	05300	ANESTHESIOLOGY	1,010,092		1,010,092	0	1,010,092	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,341,801		15,341,801	0	15,341,801	54.00
60.00	06000	LABORATORY	8,881,139		8,881,139	0	8,881,139	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,594,935		1,594,935	0	1,594,935	62.00
65.00	06500	RESPIRATORY THERAPY	3,523,502	0	3,523,502	10,899	3,534,401	65.00
66.00	06600	PHYSICAL THERAPY	2,395,753	0	2,395,753	0	2,395,753	66.00
67.00	06700	OCCUPATIONAL THERAPY	855,948	0	855,948	0	855,948	67.00
68.00	06800	SPEECH PATHOLOGY	428,675	0	428,675	0	428,675	68.00
69.00	06900	ELECTROCARDIOLOGY	4,608,856		4,608,856	10,364	4,619,220	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	579,065		579,065	4,673	583,738	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,668,363		9,668,363	0	9,668,363	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,628,590		13,628,590	0	13,628,590	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,911,666		18,911,666	0	18,911,666	73.00
74.00	07400	RENAL DIALYSIS	532,861		532,861	0	532,861	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,278,088		1,278,088	0	1,278,088	88.00
90.00	09000	CLINIC	686,067		686,067	2,553	688,620	90.00
91.00	09100	EMERGENCY	9,564,792		9,564,792	212,398	9,777,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,880,628		6,880,628		6,880,628	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	9,443,011		9,443,011		9,443,011	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,778,607		3,778,607		3,778,607	116.00
200.00		Subtotal (see instructions)	203,128,711	0	203,128,711	339,380	203,468,091	200.00
201.00		Less Observation Beds	6,880,628		6,880,628		6,880,628	201.00
202.00		Total (see instructions)	196,248,083	0	196,248,083	339,380	196,587,463	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 3/2/2015 11:13 am
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	56,339,059		56,339,059			30.00
31.00 03100 INTENSIVE CARE UNIT	27,083,875		27,083,875			31.00
40.00 04000 SUBPROVIDER - IPF	23,835,544		23,835,544			40.00
41.00 04100 SUBPROVIDER - IRF	5,230,883		5,230,883			41.00
43.00 04300 NURSERY	2,822,371		2,822,371			43.00
44.00 04400 SKILLED NURSING FACILITY	4,543,679		4,543,679			44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	25,497,175	56,227,692	81,724,867	0.276574	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5,105,093	526,531	5,631,624	0.554512	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	7,239,248	10,884,797	18,124,045	0.055732	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	32,462,138	87,794,205	120,256,343	0.127576	0.000000	54.00
60.00 06000 LABORATORY	35,495,373	48,536,753	84,032,126	0.105687	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,831,324	1,288,558	4,119,882	0.387131	0.000000	62.00
65.00 06500 RESPIRATORY THERAPY	8,403,207	2,981,768	11,384,975	0.309487	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	3,603,580	374,365	3,977,945	0.602259	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	2,046,729	55,593	2,102,322	0.407144	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	817,457	404,240	1,221,697	0.350885	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	29,735,458	42,427,277	72,162,735	0.063868	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	304,498	2,158,942	2,463,440	0.235064	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27,664,109	27,389,742	55,053,851	0.175616	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	23,460,311	17,357,430	40,817,741	0.333889	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	62,236,073	29,944,122	92,180,195	0.205160	0.000000	73.00
74.00 07400 RENAL DIALYSIS	1,041,511	77,798	1,119,309	0.476062	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	701,154	701,154	1.822835	0.000000	88.00
90.00 09000 CLINIC	139	466,977	467,116	1.468729	0.000000	90.00
91.00 09100 EMERGENCY	9,670,165	26,678,213	36,348,378	0.263142	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,500,994	16,787,573	19,288,567	0.356721	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	7,453,302	7,453,302			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	23,227	3,706,169	3,729,396			116.00
200.00	Subtotal (see instructions)	399,993,220	384,223,201	784,216,421		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	399,993,220	384,223,201	784,216,421		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 3/2/2015 11:13 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part I Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,566,263	0	2,566,263	40,145	63.92	30.00	
31.00	INTENSIVE CARE UNIT	547,348	0	547,348	4,179	130.98	31.00	
40.00	SUBPROVIDER - IPF	569,073	0	569,073	12,664	44.94	40.00	
41.00	SUBPROVIDER - IRF	261,791	0	261,791	4,927	53.13	41.00	
43.00	NURSERY	68,722		68,722	2,332	29.47	43.00	
44.00	SKILLED NURSING FACILITY	276,373		276,373	5,498	50.27	44.00	
200.00	Total (lines 30-199)	4,289,570		4,289,570	69,745		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	19,650	1,256,028					30.00
31.00	INTENSIVE CARE UNIT	2,472	323,783					31.00
40.00	SUBPROVIDER - IPF	2,622	117,833					40.00
41.00	SUBPROVIDER - IRF	3,551	188,665					41.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	4,472	224,807					44.00
200.00	Total (lines 30-199)	32,767	2,111,116					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part II Date/Time Prepared: 3/2/2015 11:13 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,752,309	81,724,867	0.045914	12,304,138	564,932	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	164,437	5,631,624	0.029199	18,646	544	52.00
53.00	05300 ANESTHESIOLOGY	230,457	18,124,045	0.012716	3,461,127	44,012	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,206,269	120,256,343	0.026662	17,461,025	465,546	54.00
60.00	06000 LABORATORY	747,605	84,032,126	0.008897	18,649,447	165,924	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	43,036	4,119,882	0.010446	1,601,299	16,727	62.00
65.00	06500 RESPIRATORY THERAPY	189,338	11,384,975	0.016631	6,258,901	104,092	65.00
66.00	06600 PHYSICAL THERAPY	130,563	3,977,945	0.032822	1,018,880	33,442	66.00
67.00	06700 OCCUPATIONAL THERAPY	33,372	2,102,322	0.015874	409,624	6,502	67.00
68.00	06800 SPEECH PATHOLOGY	17,811	1,221,697	0.014579	260,800	3,802	68.00
69.00	06900 ELECTROCARDIOLOGY	843,603	72,162,735	0.011690	17,807,968	208,175	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	92,892	2,463,440	0.037708	178,541	6,732	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	379,343	55,053,851	0.006890	12,948,940	89,218	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	572,222	40,817,741	0.014019	11,998,635	168,209	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	789,999	92,180,195	0.008570	31,905,146	273,427	73.00
74.00	07400 RENAL DIALYSIS	17,522	1,119,309	0.015654	678,783	10,626	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	67,307	701,154	0.095995	0	0	88.00
90.00	09000 CLINIC	81,769	467,116	0.175051	0	0	90.00
91.00	09100 EMERGENCY	636,324	36,348,378	0.017506	4,685,400	82,023	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	467,167	19,288,567	0.024220	1,689,376	40,917	92.00
200.00	Total (lines 50-199)	12,463,345	653,178,312		143,336,676	2,284,850	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part III Date/Time Prepared: 3/2/2015 11:13 am
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Cost Center Description			Title XVIII				Hospital	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,064,372	0	0	0	3,064,372	30.00
31.00	03100	INTENSIVE CARE UNIT	211,048	0	0	0	211,048	31.00
40.00	04000	SUBPROVIDER - IPF	316,337	0	0	0	316,337	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	59,490	0	0	0	59,490	43.00
44.00	04400	SKILLED NURSING FACILITY	334,908	0	0	0	334,908	44.00
200.00		Total (lines 30-199)	3,986,155	0	0	0	3,986,155	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,145	76.33	19,650	1,499,885		30.00
31.00	03100	INTENSIVE CARE UNIT	4,179	50.50	2,472	124,836		31.00
40.00	04000	SUBPROVIDER - IPF	12,664	24.98	2,622	65,498		40.00
41.00	04100	SUBPROVIDER - IRF	4,927	0.00	3,551	0		41.00
43.00	04300	NURSERY	2,332	25.51	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,498	60.91	4,472	272,390		44.00
200.00		Total (lines 30-199)	69,745		32,767	1,962,609		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
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Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0	218,918	0	0	218,918	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	174,064	0	0	174,064	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	331,435	0	331,435	54.00	
60.00	06000 LABORATORY	0	0	85,986	0	85,986	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0	9,443	0	0	9,443	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	130,014	0	130,014	73.00	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
90.00	09000 CLINIC	0	87,819	0	0	87,819	90.00	
91.00	09100 EMERGENCY	0	123,230	0	0	123,230	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	557,840	0	0	557,840	92.00	
200.00	Total (lines 50-199)	0	1,171,314	547,435	0	1,718,749	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet D
Part IV
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	218,918	81,724,867	0.002679	0.002679	12,304,138	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	174,064	5,631,624	0.030908	0.030908	18,646	52.00
53.00	05300	ANESTHESIOLOGY	0	18,124,045	0.000000	0.000000	3,461,127	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	331,435	120,256,343	0.002756	0.002756	17,461,025	54.00
60.00	06000	LABORATORY	85,986	84,032,126	0.001023	0.001023	18,649,447	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,119,882	0.000000	0.000000	1,601,299	62.00
65.00	06500	RESPIRATORY THERAPY	0	11,384,975	0.000000	0.000000	6,258,901	65.00
66.00	06600	PHYSICAL THERAPY	0	3,977,945	0.000000	0.000000	1,018,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,102,322	0.000000	0.000000	409,624	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,221,697	0.000000	0.000000	260,800	68.00
69.00	06900	ELECTROCARDIOLOGY	9,443	72,162,735	0.000131	0.000131	17,807,968	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,463,440	0.000000	0.000000	178,541	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,053,851	0.000000	0.000000	12,948,940	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,817,741	0.000000	0.000000	11,998,635	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,014	92,180,195	0.001410	0.001410	31,905,146	73.00
74.00	07400	RENAL DIALYSIS	0	1,119,309	0.000000	0.000000	678,783	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	701,154	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	87,819	467,116	0.188003	0.188003	0	90.00
91.00	09100	EMERGENCY	123,230	36,348,378	0.003390	0.003390	4,685,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	557,840	19,288,567	0.028921	0.028921	1,689,376	92.00
200.00		Total (lines 50-199)	1,718,749	653,178,312			143,336,676	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	32,963	20,367,024	54,563	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	576	981	30	52.00
53.00	05300 ANESTHESIOLOGY	0	3,922,094	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	48,123	29,977,902	82,619	54.00
60.00	06000 LABORATORY	19,078	6,045,354	6,184	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	644,993	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,533,075	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,333	20,984,751	2,749	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	715,328	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,920,634	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,909,608	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	44,986	8,970,725	12,649	73.00
74.00	07400 RENAL DIALYSIS	0	27,104	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000 CLINIC	0	132,464	24,904	90.00
91.00	09100 EMERGENCY	15,884	5,432,903	18,418	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	48,858	7,823,638	226,267	92.00
200.00	Total (lines 50-199)	212,801	126,408,578	428,383	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Prepared: 3/2/2015 11:13 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.276574	20,367,024	0	5,632,989	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.554512	981	0	544	52.00
53.00	05300 ANESTHESIOLOGY	0.055732	3,922,094	0	218,586	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.127576	29,977,902	0	3,824,461	54.00
60.00	06000 LABORATORY	0.105687	6,045,354	1,724	638,915	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.387131	644,993	0	249,697	62.00
65.00	06500 RESPIRATORY THERAPY	0.309487	1,533,075	0	474,467	65.00
66.00	06600 PHYSICAL THERAPY	0.602259	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.407144	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.350885	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.063868	20,984,751	0	1,340,254	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.235064	715,328	0	168,148	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175616	10,920,634	0	1,917,838	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.333889	8,909,608	0	2,974,820	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205160	8,970,725	0	1,840,434	73.00
74.00	07400 RENAL DIALYSIS	0.476062	27,104	0	12,903	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000			0	88.00
90.00	09000 CLINIC	1.468729	132,464	0	194,554	90.00
91.00	09100 EMERGENCY	0.263142	5,432,903	0	1,429,625	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.356721	7,823,638	0	2,790,856	92.00
200.00	Subtotal (see instructions)		126,408,578	1,724	23,709,091	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		126,408,578	1,724	23,709,091	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Prepared: 3/2/2015 11:13 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	182	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	182	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	182	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140015 Component CCN: 14S015		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part II Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,752,309	81,724,867	0.045914	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	164,437	5,631,624	0.029199	0	0	52.00
53.00	05300 ANESTHESIOLOGY	230,457	18,124,045	0.012716	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,206,269	120,256,343	0.026662	89,299	2,381	54.00
60.00	06000 LABORATORY	747,605	84,032,126	0.008897	576,907	5,133	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	43,036	4,119,882	0.010446	883	9	62.00
65.00	06500 RESPIRATORY THERAPY	189,338	11,384,975	0.016631	27,179	452	65.00
66.00	06600 PHYSICAL THERAPY	130,563	3,977,945	0.032822	482	16	66.00
67.00	06700 OCCUPATIONAL THERAPY	33,372	2,102,322	0.015874	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	17,811	1,221,697	0.014579	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	843,603	72,162,735	0.011690	49,877	583	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	92,892	2,463,440	0.037708	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	379,343	55,053,851	0.006890	2,672	18	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	572,222	40,817,741	0.014019	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	789,999	92,180,195	0.008570	404,877	3,470	73.00
74.00	07400 RENAL DIALYSIS	17,522	1,119,309	0.015654	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	67,307	701,154	0.095995	0	0	88.00
90.00	09000 CLINIC	81,769	467,116	0.175051	0	0	90.00
91.00	09100 EMERGENCY	636,324	36,348,378	0.017506	208,233	3,645	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19,288,567	0.000000	0	0	92.00
200.00	Total (lines 50-199)	11,996,178	653,178,312		1,360,409	15,707	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	218,918	0	0	218,918	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	174,064	0	0	174,064	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	331,435	0	331,435	54.00
60.00	06000 LABORATORY	0	0	85,986	0	85,986	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	9,443	0	0	9,443	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	130,014	0	130,014	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	87,819	0	0	87,819	90.00
91.00	09100 EMERGENCY	0	123,230	0	0	123,230	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	613,474	547,435	0	1,160,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	218,918	81,724,867	0.002679	0.002679	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	174,064	5,631,624	0.030908	0.030908	0	52.00
53.00 05300 ANESTHESIOLOGY	0	18,124,045	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	331,435	120,256,343	0.002756	0.002756	89,299	54.00
60.00 06000 LABORATORY	85,986	84,032,126	0.001023	0.001023	576,907	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,119,882	0.000000	0.000000	883	62.00
65.00 06500 RESPIRATORY THERAPY	0	11,384,975	0.000000	0.000000	27,179	65.00
66.00 06600 PHYSICAL THERAPY	0	3,977,945	0.000000	0.000000	482	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,102,322	0.000000	0.000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	1,221,697	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	9,443	72,162,735	0.000131	0.000131	49,877	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,463,440	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,053,851	0.000000	0.000000	2,672	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	40,817,741	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	130,014	92,180,195	0.001410	0.001410	404,877	73.00
74.00 07400 RENAL DIALYSIS	0	1,119,309	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	701,154	0.000000	0.000000	0	88.00
90.00 09000 CLINIC	87,819	467,116	0.188003	0.188003	0	90.00
91.00 09100 EMERGENCY	123,230	36,348,378	0.003390	0.003390	208,233	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19,288,567	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	1,160,909	653,178,312			1,360,409	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	246	0	0	54.00
60.00 06000 LABORATORY	590	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	7	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	571	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	706	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	2,120	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140015 Component CCN: 14T015		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part II Date/Time Prepared: 3/2/2015 11:13 am		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,752,309	81,724,867	0.045914	40,456	1,857	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	164,437	5,631,624	0.029199	0	0	52.00
53.00	05300	ANESTHESIOLOGY	230,457	18,124,045	0.012716	8,454	108	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,206,269	120,256,343	0.026662	265,975	7,091	54.00
60.00	06000	LABORATORY	747,605	84,032,126	0.008897	697,804	6,208	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	43,036	4,119,882	0.010446	29,213	305	62.00
65.00	06500	RESPIRATORY THERAPY	189,338	11,384,975	0.016631	126,580	2,105	65.00
66.00	06600	PHYSICAL THERAPY	130,563	3,977,945	0.032822	1,006,717	33,042	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,372	2,102,322	0.015874	672,306	10,672	67.00
68.00	06800	SPEECH PATHOLOGY	17,811	1,221,697	0.014579	278,238	4,056	68.00
69.00	06900	ELECTROCARDIOLOGY	843,603	72,162,735	0.011690	39,143	458	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,892	2,463,440	0.037708	6,539	247	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	379,343	55,053,851	0.006890	92,623	638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	572,222	40,817,741	0.014019	29,904	419	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	789,999	92,180,195	0.008570	1,000,742	8,576	73.00
74.00	07400	RENAL DIALYSIS	17,522	1,119,309	0.015654	22,710	356	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	67,307	701,154	0.095995	0	0	88.00
90.00	09000	CLINIC	81,769	467,116	0.175051	0	0	90.00
91.00	09100	EMERGENCY	636,324	36,348,378	0.017506	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	19,288,567	0.000000	0	0	92.00
200.00		Total (lines 50-199)	11,996,178	653,178,312		4,317,404	76,138	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	218,918	0	0	218,918	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	174,064	0	0	174,064	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	331,435	0	331,435	54.00
60.00	06000 LABORATORY	0	0	85,986	0	85,986	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	9,443	0	0	9,443	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	130,014	0	130,014	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	87,819	0	0	87,819	90.00
91.00	09100 EMERGENCY	0	123,230	0	0	123,230	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	613,474	547,435	0	1,160,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	218,918	81,724,867	0.002679	0.002679	40,456	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	174,064	5,631,624	0.030908	0.030908	0	52.00
53.00 05300 ANESTHESIOLOGY	0	18,124,045	0.000000	0.000000	8,454	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	331,435	120,256,343	0.002756	0.002756	265,975	54.00
60.00 06000 LABORATORY	85,986	84,032,126	0.001023	0.001023	697,804	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,119,882	0.000000	0.000000	29,213	62.00
65.00 06500 RESPIRATORY THERAPY	0	11,384,975	0.000000	0.000000	126,580	65.00
66.00 06600 PHYSICAL THERAPY	0	3,977,945	0.000000	0.000000	1,006,717	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,102,322	0.000000	0.000000	672,306	67.00
68.00 06800 SPEECH PATHOLOGY	0	1,221,697	0.000000	0.000000	278,238	68.00
69.00 06900 ELECTROCARDIOLOGY	9,443	72,162,735	0.000131	0.000131	39,143	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,463,440	0.000000	0.000000	6,539	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,053,851	0.000000	0.000000	92,623	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	40,817,741	0.000000	0.000000	29,904	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	130,014	92,180,195	0.001410	0.001410	1,000,742	73.00
74.00 07400 RENAL DIALYSIS	0	1,119,309	0.000000	0.000000	22,710	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	701,154	0.000000	0.000000	0	88.00
90.00 09000 CLINIC	87,819	467,116	0.188003	0.188003	0	90.00
91.00 09100 EMERGENCY	123,230	36,348,378	0.003390	0.003390	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19,288,567	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	1,160,909	653,178,312			4,317,404	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	108	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	733	0	0	54.00
60.00 06000 LABORATORY	714	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	5	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,411	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	2,971	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	218,918	0	0	218,918	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	174,064	0	0	174,064	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	331,435	0	331,435	54.00
60.00	06000 LABORATORY	0	0	85,986	0	85,986	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	9,443	0	0	9,443	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	130,014	0	130,014	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	87,819	0	0	87,819	90.00
91.00	09100 EMERGENCY	0	123,230	0	0	123,230	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	613,474	547,435	0	1,160,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	218,918	81,724,867	0.002679	0.002679	152	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	174,064	5,631,624	0.030908	0.030908	0	52.00
53.00 05300 ANESTHESIOLOGY	0	18,124,045	0.000000	0.000000	209	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	331,435	120,256,343	0.002756	0.002756	160,763	54.00
60.00 06000 LABORATORY	85,986	84,032,126	0.001023	0.001023	884,479	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,119,882	0.000000	0.000000	36,699	62.00
65.00 06500 RESPIRATORY THERAPY	0	11,384,975	0.000000	0.000000	539,265	65.00
66.00 06600 PHYSICAL THERAPY	0	3,977,945	0.000000	0.000000	664,513	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	2,102,322	0.000000	0.000000	439,837	67.00
68.00 06800 SPEECH PATHOLOGY	0	1,221,697	0.000000	0.000000	48,634	68.00
69.00 06900 ELECTROCARDIOLOGY	9,443	72,162,735	0.000131	0.000131	72,308	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,463,440	0.000000	0.000000	7,449	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,053,851	0.000000	0.000000	186,873	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	40,817,741	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	130,014	92,180,195	0.001410	0.001410	2,412,162	73.00
74.00 07400 RENAL DIALYSIS	0	1,119,309	0.000000	0.000000	54,374	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	701,154	0.000000	0.000000	0	88.00
90.00 09000 CLINIC	87,819	467,116	0.188003	0.188003	0	90.00
91.00 09100 EMERGENCY	123,230	36,348,378	0.003390	0.003390	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19,288,567	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	1,160,909	653,178,312			5,507,717	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 3/2/2015 11:13 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	443	0	0	54.00
60.00 06000 LABORATORY	905	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	9	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,401	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	4,758	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 3/2/2015 11:13 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		40,145	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		40,145	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		32,837	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		19,650	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		37,797,140	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		37,797,140	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		37,797,140	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		941.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		18,500,868	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		18,500,868	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1	
		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	7,424,759	4,179	1,776.68	2,472	4,391,953	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					27,445,312	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					50,338,133	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,204,532	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,497,651	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,702,183	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					44,635,950	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					7,308	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					941.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,880,628	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 3/2/2015 11:13 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,566,263	37,797,140	0.067896	6,880,628	467,167	90.00
91.00	Nursing School cost	3,064,372	37,797,140	0.081074	6,880,628	557,840	91.00
92.00	Allied health cost	0	37,797,140	0.000000	6,880,628	0	92.00
93.00	All other Medical Education	0	37,797,140	0.000000	6,880,628	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			12,664 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			12,664 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			12,664 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			2,622 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			10,029,407 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			10,029,407 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			10,029,407 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			791.96 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,076,519 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			2,076,519 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 14S015		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					224,173	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,300,692	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					183,331	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					17,827	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					201,158	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,099,534	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 14S015		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	569,073	10,029,407	0.056740	0	0	90.00
91.00	Nursing School cost	316,337	10,029,407	0.031541	0	0	91.00
92.00	Allied health cost	0	10,029,407	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,029,407	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1
		Component CCN: 14T015		Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,927	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,927	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,927	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,551	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,665,200	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,665,200	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,665,200	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		743.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,641,589	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,641,589	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1	
		Component CCN: 14T015				Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,394,071		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,035,660		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					188,665		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					79,109		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					267,774		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,767,886		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 14T015		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	261,791	3,665,200	0.071426	0	0	90.00
91.00	Nursing School cost	0	3,665,200	0.000000	0	0	91.00
92.00	Allied health cost	0	3,665,200	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,665,200	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,498	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,498	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,498	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,472	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,997,014	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,997,014	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,997,014	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015	Period:	Worksheet D-1		
		Component CCN: 145643	From 10/01/2013 To 09/30/2014	Date/Time Prepared: 3/2/2015 11:13 am		
		Title XVIII	Skilled Nursing Facility	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
	Cost Center Description					
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49.00
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
	TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges					54.00
55.00	Target amount per discharge					55.00
56.00	Target amount (line 54 x line 55)					56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00	Bonus payment (see instructions)					58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					61.00
62.00	Relief payment (see instructions)					62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					3,997,014 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					726.99 71.00
72.00	Program routine service cost (line 9 x line 71)					3,251,099 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					3,251,099 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)					0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0 80.00
81.00	Inpatient routine service cost per diem limitation					0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)					3,251,099 83.00
84.00	Program inpatient ancillary services (see instructions)					1,451,447 84.00
85.00	Utilization review - physician compensation (see instructions)					0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					4,702,546 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 145643		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Prepared: 3/2/2015 11:13 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		36,062,738		30.00
31.00	03100 INTENSIVE CARE UNIT		15,683,081		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.277499	12,304,138	3,414,386	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.554512	18,646	10,339	52.00
53.00	05300 ANESTHESIOLOGY	0.055732	3,461,127	192,896	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.127576	17,461,025	2,227,608	54.00
60.00	06000 LABORATORY	0.105687	18,649,447	1,971,004	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.387131	1,601,299	619,912	62.00
65.00	06500 RESPIRATORY THERAPY	0.310444	6,258,901	1,943,038	65.00
66.00	06600 PHYSICAL THERAPY	0.602259	1,018,880	613,630	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.407144	409,624	166,776	67.00
68.00	06800 SPEECH PATHOLOGY	0.350885	260,800	91,511	68.00
69.00	06900 ELECTROCARDIOLOGY	0.064011	17,807,968	1,139,906	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.236961	178,541	42,307	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175616	12,948,940	2,274,041	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.333889	11,998,635	4,006,212	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205160	31,905,146	6,545,660	73.00
74.00	07400 RENAL DIALYSIS	0.476062	678,783	323,143	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.474195	0	0	90.00
91.00	09100 EMERGENCY	0.268986	4,685,400	1,260,307	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.356721	1,689,376	602,636	92.00
200.00	Total (sum of lines 50-94 and 96-98)		143,336,676	27,445,312	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		143,336,676		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		4,943,543	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.277499	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.554512	0	52.00
53.00	05300 ANESTHESIOLOGY	0.055732	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.127576	89,299	54.00
60.00	06000 LABORATORY	0.105687	576,907	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.387131	883	62.00
65.00	06500 RESPIRATORY THERAPY	0.310444	27,179	65.00
66.00	06600 PHYSICAL THERAPY	0.602259	482	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.407144	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.350885	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.064011	49,877	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.236961	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175616	2,672	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.333889	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205160	404,877	73.00
74.00	07400 RENAL DIALYSIS	0.476062	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000 CLINIC	1.474195	0	90.00
91.00	09100 EMERGENCY	0.268986	208,233	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.356721	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,360,409	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		1,360,409	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		3,789,691	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.277499	40,456	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.554512	0	52.00
53.00	05300 ANESTHESIOLOGY	0.055732	8,454	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.127576	265,975	54.00
60.00	06000 LABORATORY	0.105687	697,804	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.387131	29,213	62.00
65.00	06500 RESPIRATORY THERAPY	0.310444	126,580	65.00
66.00	06600 PHYSICAL THERAPY	0.602259	1,006,717	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.407144	672,306	67.00
68.00	06800 SPEECH PATHOLOGY	0.350885	278,238	68.00
69.00	06900 ELECTROCARDIOLOGY	0.064011	39,143	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.236961	6,539	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175616	92,623	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.333889	29,904	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205160	1,000,742	73.00
74.00	07400 RENAL DIALYSIS	0.476062	22,710	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	1.474195	0	90.00
91.00	09100 EMERGENCY	0.268986	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.356721	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,317,404	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		4,317,404	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.276574	152	42 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.554512	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.055732	209	12 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.127576	160,763	20,510 54.00
60.00	06000 LABORATORY	0.105687	884,479	93,478 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.387131	36,699	14,207 62.00
65.00	06500 RESPIRATORY THERAPY	0.309487	539,265	166,896 65.00
66.00	06600 PHYSICAL THERAPY	0.602259	664,513	400,209 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.407144	439,837	179,077 67.00
68.00	06800 SPEECH PATHOLOGY	0.350885	48,634	17,065 68.00
69.00	06900 ELECTROCARDIOLOGY	0.063868	72,308	4,618 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.235064	7,449	1,751 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175616	186,873	32,818 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.333889	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205160	2,412,162	494,879 73.00
74.00	07400 RENAL DIALYSIS	0.476062	54,374	25,885 74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000 CLINIC	1.468729	0	0 90.00
91.00	09100 EMERGENCY	0.263142	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.356721	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,507,717	1,451,447 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		5,507,717	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		37,896,555		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		0		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0		1.03
2.00	Outlier payments for discharges. (see instructions)		1,298,272		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		143,466		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		168.98		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		19.50		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		19.50		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		18.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		18.00		12.00
13.00	Total allowable FTE count for the prior year.		16.06		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		16.71		14.00
15.00	Sum of lines 12 through 14 divided by 3.		16.92		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		16.92		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.100130		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.096162		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.096162		21.00
22.00	IME payment adjustment (see instructions)		1,945,557		22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-1.50		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		1,945,557		29.00
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.33		30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.82		31.00
32.00	Sum of lines 30 and 31		20.15		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		5.85	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		554,237		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		35.00
35.01	Factor 3 (see instructions)		0.00000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,870,422		36.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		44,565,043		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		46,083,674		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		46,083,674		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		3,267,691		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		575,244		52.00
53.00	Nursing and Allied Health Managed Care payment		146,394		53.00
54.00	Special add-on payments for new technologies		2,066		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		1,624,721		57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		212,801		58.00
59.00	Total (sum of amounts on lines 49 through 58)		51,912,591		59.00
60.00	Primary payer payments		24,772		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		51,887,819		61.00
62.00	Deductibles billed to program beneficiaries		4,382,967		62.00
63.00	Coinurance billed to program beneficiaries		21,528		63.00
64.00	Allowable bad debts (see instructions)		750,937		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		488,109		65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		750,937		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		47,971,433		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-31,829		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-106,115		70.94
70.95	Recovery of accelerated depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		47,833,489		71.00
71.01	Sequestration adjustment (see instructions)		956,670		71.01
72.00	Interim payments		48,529,521		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-1,652,702		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,535,000		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 3/2/2015 11:13 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		182	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23,280,708	2.00
3.00	PPS payments		24,764,192	3.00
4.00	Outlier payment (see instructions)		163,722	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.897	5.00
6.00	Line 2 times line 5		20,882,795	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		428,383	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		182	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,724	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,724	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,724	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,542	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		182	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		25,356,297	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		5,420,566	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		19,935,913	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		222,166	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		20,158,079	30.00
31.00	Primary payer payments		1,556	31.00
32.00	Subtotal (line 30 minus line 31)		20,156,523	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		745,028	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		484,268	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		745,028	36.00
37.00	Subtotal (see instructions)		20,640,791	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-108	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		20,640,899	40.00
40.01	Sequestration adjustment (see instructions)		412,818	40.01
41.00	Interim payments		20,238,775	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-10,694	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
3/2/2015 11:13 am

		Title XVIII		Hospital		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		48,478,070		20,326,985	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	05/30/2014	853,444	09/19/2014	2,936	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	09/19/2014	801,993	05/30/2014	91,146	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)		51,451		-88,210	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		48,529,521		20,238,775	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		1,652,702		10,694	6.02	
7.00	Total Medicare program liability (see instructions)		46,876,819		20,228,081	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015
Component CCN: 14S015

Period:
From 10/01/2013
To 09/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
3/2/2015 11:13 am

Title XVIII

Subprovider -
IPF

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					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,800,009		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,800,009		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		184,072		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,984,081		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015
Component CCN: 14T015

Period:
From 10/01/2013
To 09/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
3/2/2015 11:13 am

Title XVIII

Subprovider -
IRF

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, write "NONE" or enter a zero		5,189,595			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)					0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/30/2014	6,583			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)		6,583			0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,196,178			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)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		0			0 6.01
6.02	SETTLEMENT TO PROGRAM		9,402			0 6.02
7.00	Total Medicare program liability (see instructions)		5,186,776			0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015
Component CCN: 145643

Period:
From 10/01/2013
To 09/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
3/2/2015 11:13 am

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					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,562,588		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,562,588		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		271,666		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,834,254		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			10,090 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			22,122 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			2,062 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			37,016 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			784,216,421 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			142,337,312 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			755,935 8.00
9.00	Sequestration adjustment amount (see instructions)			15,119 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			740,816 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			740,816 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part II Date/Time Prepared: 3/2/2015 11:13 am
		Title XVII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,194,898 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			34.695890 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9))) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,194,898 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,194,898 16.00
17.00	Primary payer payments			571 17.00
18.00	Subtotal (line 16 less line 17).			2,194,327 18.00
19.00	Deductibles			304,480 19.00
20.00	Subtotal (line 18 minus line 19)			1,889,847 20.00
21.00	Coinsurance			53,056 21.00
22.00	Subtotal (line 20 minus line 21)			1,836,791 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			184,866 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			120,163 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,956,954 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			67,618 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,024,572 31.00
31.01	Sequestration adjustment (see instructions)			40,491 31.01
32.00	Interim payments			1,800,009 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33			184,072 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part III Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			5,062,133 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0107 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			121,997 3.00
4.00	Outlier Payments			160,580 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			13.498630 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			5,344,710 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			5,344,710 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			5,344,710 19.00
20.00	Deductibles			32,576 20.00
21.00	Subtotal (line 19 minus line 20)			5,312,134 21.00
22.00	Coinsurance			25,536 22.00
23.00	Subtotal (line 21 minus line 22)			5,286,598 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			4,708 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			3,060 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,708 26.00
27.00	Subtotal (sum of lines 23 and 25)			5,289,658 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			2,971 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			5,292,629 32.00
32.01	Sequestration adjustment (see instructions)			105,853 32.01
33.00	Interim payments			5,196,178 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34			-9,402 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			160,580 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VI Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,662,806	1.00
2.00	Routine service other pass through costs		272,390	2.00
3.00	Ancillary service other pass through costs		4,758	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,939,954	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		68,328	7.00
8.00	Allowable bad debts (see instructions)		81	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		81	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		62	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		1,871,688	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		1,871,688	15.00
15.01	Sequestration adjustment (see instructions)		37,434	15.01
16.00	Interim payments		1,562,588	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		271,666	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet E-4 Date/Time Prepared: 3/2/2015 11:13 am	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			18.00	6.00
7.00	Enter the lesser of line 5 or line 6			18.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	18.00	0.00	18.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	18.00	0.00	18.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	18.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	18.09	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	16.71	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.60	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	17.60	0.00		17.00
18.00	Per resident amount	81,362.88	0.00		18.00
19.00	Approved amount for resident costs	1,431,987	0	1,431,987	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,431,987	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	28,295	2,461		26.00
27.00	Total Inpatient Days (see instructions)	54,607	54,607		27.00
28.00	Ratio of inpatient days to total inpatient days	0.518157	0.045067		28.00
29.00	Program direct GME amount	741,994	64,535		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		9,119		30.00
31.00	Net Program direct GME amount			797,410	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet E-4 Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,119,309	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		61,865,538	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		25,343	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		61,840,195	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		23,887,198	42.00
43.00	Primary payer payments (see instructions)		3,680	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		23,883,518	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		85,723,713	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.721390	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.278610	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		797,410	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		575,244	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		222,166	50.00

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

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet G

Date/Time Prepared:
3/2/2015 11:13 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	100,782,056	0	0	0	1.00
2.00	Temporary investments	89,864,986	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	143,938,641	0	0	0	4.00
5.00	Other receivable	7,912,388	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-93,980,864	0	0	0	6.00
7.00	Inventory	6,499,852	0	0	0	7.00
8.00	Prepaid expenses	4,609,690	0	0	0	8.00
9.00	Other current assets	165,513	0	0	0	9.00
10.00	Due from other funds	3,723,567	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	263,515,829	0	0	0	11.00
FIXED ASSETS						
12.00	Land	12,900,770	0	0	0	12.00
13.00	Land improvements	7,023,811	0	0	0	13.00
14.00	Accumulated depreciation	-4,816,641	0	0	0	14.00
15.00	Buildings	195,049,162	0	0	0	15.00
16.00	Accumulated depreciation	-62,414,262	0	0	0	16.00
17.00	Leasehold improvements	4,663,198	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	-31,283,060	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	160,488,259	0	0	0	23.00
24.00	Accumulated depreciation	-121,314,111	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	160,297,126	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	15,906,305	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,854,087	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	25,760,392	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	449,573,347	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	21,918,365	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,206,595	0	0	0	38.00
39.00	Payroll taxes payable	658,167	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,793,071	0	0	0	40.00
41.00	Deferred income	1,163,670	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	14,162,796	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	59,902,664	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	96,528,690	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	72,255,334	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	168,784,024	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	228,686,688	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	220,886,659				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	220,886,659	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	449,573,347	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet G-1

Date/Time Prepared:
3/2/2015 11:13 am

		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		212,704,292		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		26,149,075			2.00
3.00	Total (sum of line 1 and line 2)		238,853,367		0	3.00
4.00	CONTRIBUTIONS	5,540,190		0		4.00
5.00	OTHER	10,634		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		5,550,824		0	10.00
11.00	Subtotal (line 3 plus line 10)		244,404,191		0	11.00
12.00	PENSION LIABILITY ADJUSTMENT	18,446,034		0		12.00
13.00	NET ASSETS RELEASED	5,071,498		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		23,517,532		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		220,886,659		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	CONTRIBUTIONS		0			4.00
5.00	OTHER		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	PENSION LIABILITY ADJUSTMENT		0			12.00
13.00	NET ASSETS RELEASED		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	59,765,063		59,765,063	1.00
2.00	SUBPROVIDER - IPF	24,039,826		24,039,826	2.00
3.00	SUBPROVIDER - IRF	5,322,146		5,322,146	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,567,712		4,567,712	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	93,694,747		93,694,747	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	27,692,323		27,692,323	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	27,692,323		27,692,323	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	121,387,070		121,387,070	17.00
18.00	Ancillary services	303,084,918	431,205,118	734,290,036	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	701,154	701,154	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		7,453,302	7,453,302	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	23,227	3,706,169	3,729,396	26.00
27.00	NURSERY	3,023,036	0	3,023,036	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	427,518,251	443,065,743	870,583,994	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		288,281,822		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		288,281,822		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140015

Period:
From 10/01/2013
To 09/30/2014

Worksheet G-3

Date/Time Prepared:
3/2/2015 11:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	870,583,994	1.00
2.00	Less contractual allowances and discounts on patients' accounts	581,472,651	2.00
3.00	Net patient revenues (line 1 minus line 2)	289,111,343	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	288,281,822	4.00
5.00	Net income from service to patients (line 3 minus line 4)	829,521	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	5,767,234	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	422,690	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,661,232	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	104,836	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	3,231,378	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	904,164	22.00
23.00	Governmental appropriations	0	23.00
24.00	TRANSFERS	1,555,508	24.00
24.01	TRANSFERS	447,156	24.01
24.02	MISCELLANEOUS INCOME	11,225,356	24.02
25.00	Total other income (sum of lines 6-24)	25,319,554	25.00
26.00	Total (line 5 plus line 25)	26,149,075	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	26,149,075	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2013
To 09/30/2014

Worksheet H
Date/Time Prepared:
3/2/2015 11:13 am

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	473,061	0	0	0	473,061	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,440,412	0	69,818	0	2,200,311	6.00
7.00	Physical Therapy	981,143	0	31,874	0	1,328,060	7.00
8.00	Occupational Therapy	291,995	0	11,168	0	413,545	8.00
9.00	Speech Pathology	45,368	0	1,472	0	61,384	9.00
10.00	Medical Social Services	122,889	0	210	0	125,177	10.00
11.00	Home Health Aide	239,407	0	16,844	0	422,733	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	7,943	0	0	36,773	44,716	22.00
23.00	All Others (specify)	198,896	0	0	80,088	278,984	23.00
24.00	Total (sum of lines 1-23)	3,801,114	0	131,386	0	5,347,971	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	473,061	0	473,061		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	-1,678	2,198,633	-150	2,198,483		6.00
7.00	Physical Therapy	0	1,328,060	0	1,328,060		7.00
8.00	Occupational Therapy	0	413,545	0	413,545		8.00
9.00	Speech Pathology	0	61,384	0	61,384		9.00
10.00	Medical Social Services	0	125,177	0	125,177		10.00
11.00	Home Health Aide	0	422,733	0	422,733		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	44,716	0	44,716		22.00
23.00	All Others (specify)	0	278,984	-10,000	268,984		23.00
24.00	Total (sum of lines 1-23)	-1,678	5,346,293	-10,150	5,336,143		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet H-1 Part I Date/Time Prepared: 3/2/2015 11:13 am
		HHA CCN: 147031	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	473,061	0	0	0	473,061	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	2,198,483	0	0	0	2,198,483	6.00
7.00	Physical Therapy	1,328,060	0	0	0	1,328,060	7.00
8.00	Occupational Therapy	413,545	0	0	0	413,545	8.00
9.00	Speech Pathology	61,384	0	0	0	61,384	9.00
10.00	Medical Social Services	125,177	0	0	0	125,177	10.00
11.00	Home Health Aide	422,733	0	0	0	422,733	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	44,716	0	0	0	44,716	22.00
23.00	All Others (specify)	268,984	0	0	0	268,984	23.00
24.00	Total (sum of lines 1-23)	5,336,143	0	0	0	5,336,143	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	473,061					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	213,859	2,412,342				6.00
7.00	Physical Therapy	129,188	1,457,248				7.00
8.00	Occupational Therapy	40,228	453,773				8.00
9.00	Speech Pathology	5,971	67,355				9.00
10.00	Medical Social Services	12,177	137,354				10.00
11.00	Home Health Aide	41,122	463,855				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	4,350	49,066				22.00
23.00	All Others (specify)	26,166	295,150				23.00
24.00	Total (sum of lines 1-23)		5,336,143				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2013
To 09/30/2014

Worksheet H-1
Part II
Date/Time Prepared:
3/2/2015 11:13 am

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-473,061	4,863,082
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	2,198,483
7.00	Physical Therapy	0	0	0	0	0	1,328,060
8.00	Occupational Therapy	0	0	0	0	0	413,545
9.00	Speech Pathology	0	0	0	0	0	61,384
10.00	Medical Social Services	0	0	0	0	0	125,177
11.00	Home Health Aide	0	0	0	0	0	422,733
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	44,716
23.00	All Others (specify)	0	0	0	0	0	268,984
24.00	Total (sum of lines 1-23)	0	0	0	0	-473,061	4,863,082
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		473,061
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.097276

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2013
To 09/30/2014

Worksheet H-2
Part I
Date/Time Prepared:
3/2/2015 11:13 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	14TH STREET	
		BLDG & FIXT						
	0	1.00		1.01	1.02	1.03	1.04	
1.00 Administrative and General	0	0	0	0	0	0	4,888	1.00
2.00 Skilled Nursing Care	2,412,342	0	0	0	0	0	0	2.00
3.00 Physical Therapy	1,457,248	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	453,773	0	0	0	0	0	0	4.00
5.00 Speech Pathology	67,355	0	0	0	0	0	0	5.00
6.00 Medical Social Services	137,354	0	0	0	0	0	0	6.00
7.00 Home Health Aide	463,855	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	49,066	0	0	0	0	0	0	18.00
19.00 All Others (specify)	295,150	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	5,336,143	0	0	0	0	0	4,888	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	
	MOB PHASE I	MVBLE EQUIP					
	1.05	2.00					
1.00 Administrative and General	0	10,387	88,762	104,037	29,700	91,506	1.00
2.00 Skilled Nursing Care	0	0	270,268	2,682,610	765,832	0	2.00
3.00 Physical Therapy	0	0	184,095	1,641,343	468,571	0	3.00
4.00 Occupational Therapy	0	0	54,788	508,561	145,184	0	4.00
5.00 Speech Pathology	0	0	8,513	75,868	21,659	0	5.00
6.00 Medical Social Services	0	0	23,058	160,412	45,794	0	6.00
7.00 Home Health Aide	0	0	44,921	508,776	145,245	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	1,490	50,556	14,433	0	18.00
19.00 All Others (specify)	0	0	37,319	332,469	94,913	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	10,387	713,214	6,064,632	1,731,331	91,506	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2013
To 09/30/2014

Worksheet H-2
Part I
Date/Time Prepared:
3/2/2015 11:13 am

Home Health
Agency I

PPS

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	129,995	0	174,332	709,508	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	129,995	0	174,332	709,508	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

Cost Center Description		INTERNS & RESIDENTS						
		NURSING SCHOOL	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	
		20.00	21.00	22.00	23.00	23.01	23.02	
1.00	Administrative and General	541,707	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	541,707	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015

Period: From 10/01/2013

Worksheet H-2

HHA CCN: 147031

To 09/30/2014

Part I
Date/Time Prepared:
3/2/2015 11:13 am

Home Health Agency I

PPS

Cost Center Description	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	23.03	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	0	1,780,785	0	1,780,785			1.00
2.00 Skilled Nursing Care	0	3,448,442	0	3,448,442	801,455	4,249,897	2.00
3.00 Physical Therapy	0	2,109,914	0	2,109,914	490,367	2,600,281	3.00
4.00 Occupational Therapy	0	653,745	0	653,745	151,938	805,683	4.00
5.00 Speech Pathology	0	97,527	0	97,527	22,666	120,193	5.00
6.00 Medical Social Services	0	206,206	0	206,206	47,925	254,131	6.00
7.00 Home Health Aide	0	654,021	0	654,021	152,002	806,023	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	64,989	0	64,989	15,104	80,093	18.00
19.00 All Others (specify)	0	427,382	0	427,382	99,328	526,710	19.00
20.00 Total (sum of lines 1-19) (2)	0	9,443,011	0	9,443,011	1,780,785	9,443,011	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.232411		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2013
To 09/30/2014

Worksheet H-2
Part II
Date/Time Prepared:
3/2/2015 11:13 am
PPS

Cost Center Description		CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	0	0	0	0	4,925	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	4,925	0	20.00
21.00	Total cost to be allocated	0	0	0	0	4,888	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.992487	0.000000	22.00

Cost Center Description		CAPITAL RELATED COSTS		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)					
		2.00	4.00					
1.00	Administrative and General	10,436	473,061	0	104,037	4,925	0	1.00
2.00	Skilled Nursing Care	0	1,440,412	0	2,682,610	0	0	2.00
3.00	Physical Therapy	0	981,143	0	1,641,343	0	0	3.00
4.00	Occupational Therapy	0	291,995	0	508,561	0	0	4.00
5.00	Speech Pathology	0	45,368	0	75,868	0	0	5.00
6.00	Medical Social Services	0	122,889	0	160,412	0	0	6.00
7.00	Home Health Aide	0	239,407	0	508,776	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	7,943	0	50,556	0	0	18.00
19.00	All Others (specify)	0	198,896	0	332,469	0	0	19.00
20.00	Total (sum of lines 1-19)	10,436	3,801,114		6,064,632	4,925	0	20.00
21.00	Total cost to be allocated	10,387	713,214		1,731,331	91,506	0	21.00
22.00	Unit cost multiplier	0.995305	0.187633		0.285480	18.579898	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2013
To 09/30/2014

Worksheet H-2
Part II
Date/Time Prepared:
3/2/2015 11:13 am
PPS

Cost Center Description		HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	
		9.00	10.00	11.00	13.00	16.00	20.00	
1.00	Administrative and General	3,683	0	19,051	118,585	0	3,442	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	3,683	0	19,051	118,585	0	3,442	20.00
21.00	Total cost to be allocated	129,995	0	174,332	709,508	0	541,707	21.00
22.00	Unit cost multiplier	35.295954	0.000000	9.150806	5.983118	0.000000	157.381464	22.00

Cost Center Description		INTERNS & RESIDENTS						
		SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
		21.00	22.00	23.00	23.01	23.02	23.03	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 140015 HHA CCN: 147031	Period: From 10/01/2013 To 09/30/2014	Worksheet H-3 Part I Date/Time Prepared: 3/2/2015 11:13 am
			Title XVIII	Home Health Agency I	PPS

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	4,249,897		4,249,897	29,595	143.60	1.00
2.00	Physical Therapy	3.00	2,600,281	0	2,600,281	13,510	192.47	2.00
3.00	Occupational Therapy	4.00	805,683	0	805,683	4,735	170.15	3.00
4.00	Speech Pathology	5.00	120,193	0	120,193	626	192.00	4.00
5.00	Medical Social Services	6.00	254,131		254,131	89	2,855.40	5.00
6.00	Home Health Aide	7.00	806,023		806,023	7,142	112.86	6.00
7.00	Total (sum of lines 1-6)		8,836,208	0	8,836,208	55,697		7.00

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

Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	946	19,722		8.00
8.01	Skilled Nursing Care		99926	133	1,906		8.01
9.00	Physical Therapy		99914	449	9,953		9.00
9.01	Physical Therapy		99926	39	810		9.01
10.00	Occupational Therapy		99914	137	3,316		10.00
10.01	Occupational Therapy		99926	31	330		10.01
11.00	Speech Pathology		99914	16	507		11.00
11.01	Speech Pathology		99926	0	21		11.01
12.00	Medical Social Services		99914	4	59		12.00
12.01	Medical Social Services		99926	1	7		12.01
13.00	Home Health Aide		99914	98	5,296		13.00
13.01	Home Health Aide		99926	51	919		13.01
14.00	Total (sum of lines 8-13)			1,905	42,846		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	10,847	10,847	61,767	0.175612	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description	Part A	Program Visits		Part A	Cost of Services	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00		

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	1,079	21,628		154,944	3,105,781	1.00
2.00	Physical Therapy	488	10,763		93,925	2,071,555	2.00
3.00	Occupational Therapy	168	3,646		28,585	620,367	3.00
4.00	Speech Pathology	16	528		3,072	101,376	4.00
5.00	Medical Social Services	5	66		14,277	188,456	5.00
6.00	Home Health Aide	149	6,215		16,816	701,425	6.00
7.00	Total (sum of lines 1-6)	1,905	42,846		311,619	6,788,960	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140015 HHA CCN: 147031	Period: From 10/01/2013 To 09/30/2014	Worksheet H-3 Part I Date/Time Prepared: 3/2/2015 11:13 am
				Title XVII I	Home Health Agency I	PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00
Cost Center Description		Program Covered Charges			Cost of Services		
		Part A	Part B		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies						15.00
16.00	Cost of Drugs		0	0		0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)					
		12.00					
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	3,260,725					1.00
2.00	Physical Therapy	2,165,480					2.00
3.00	Occupational Therapy	648,952					3.00
4.00	Speech Pathology	104,448					4.00
5.00	Medical Social Services	202,733					5.00
6.00	Home Health Aide	718,241					6.00
7.00	Total (sum of lines 1-6)	7,100,579					7.00
Cost Center Description							
		12.00					
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2013
To 09/30/2014

Worksheet H-3
Part II
Date/Time Prepared:
3/2/2015 11:13 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.602259	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.407144	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.350885	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.175616	61,767	10,847	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.205160	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140015 HHA CCN: 147031	Period: From 10/01/2013 To 09/30/2014	Worksheet H-4 Part I-11 Date/Time Prepared: 3/2/2015 11:13 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	257,762	5,648,337	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	257,762	5,648,337	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	257,762	5,648,337	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	1,986	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	-1,986
11.00	Total PPS Reimbursement - Full Episodes without Outliers		262,411	4,943,351
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	359,274
13.00	Total PPS Reimbursement - LUPA Episodes		819	52,115
14.00	Total PPS Reimbursement - PEP Episodes		4,013	49,320
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	107,185
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	1,585
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		267,243	5,510,844
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		267,243	5,510,844
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		267,243	5,510,844
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		267,243	5,510,844
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		267,243	5,510,844
31.01	Sequestration adjustment (see instructions)		5,345	110,218
32.00	Interim payments (see instructions)		261,898	5,400,626
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140015	Period: From 10/01/2013	Worksheet H-5
	HHA CCN: 147031	To 09/30/2014	Date/Time Prepared: 3/2/2015 11:13 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		261,898		5,400,626	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		261,898		5,400,626	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		261,898		5,400,626	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015

Period: From 10/01/2013

Worksheet K

Hospice CCN: 141501

To 09/30/2014

Date/Time Prepared: 3/2/2015 11:13 am

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	385,678	0	81,611	0	201,953	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	28,300	0	0	48,000	0	9.00
10.00	Nursing Care	924,046	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	201,558	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	74,172	0	0	79,824	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	141,186	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	42,912	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,613,754	0	81,611	127,824	386,051	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015

Period: From 10/01/2013

Worksheet K

Hospice CCN: 141501

To 09/30/2014

Date/Time Prepared: 3/2/2015 11:13 am

		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	669,242	0	669,242	0	669,242	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	76,300	0	76,300	-27,952	48,348	9.00
10.00	Nursing Care	924,046	0	924,046	0	924,046	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	201,558	0	201,558	0	201,558	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	153,996	0	153,996	0	153,996	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	141,186	0	141,186	0	141,186	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	42,912	-168	42,744	0	42,744	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,209,240	-168	2,209,072	-27,952	2,181,120	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2013
 To 09/30/2014

Worksheet K-1
 Date/Time Prepared:
 3/2/2015 11:13 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	924,046	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	201,558	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	201,558	0	924,046	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015

Period: From 10/01/2013

Worksheet K-1

Hospice CCN: 141501

To 09/30/2014

Date/Time Prepared: 3/2/2015 11:13 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	385,678	385,678	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	28,300	28,300	9.00
10.00	Nursing Care		0	0	924,046	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	201,558	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		74,172	0	74,172	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	74,172	413,978	1,613,754	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140015	Period:	Worksheet K-3
		Hospice CCN: 141501	From 10/01/2013 To 09/30/2014	Date/Time Prepared: 3/2/2015 11:13 am

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140015	Period:	Worksheet K-3
		Hospice CCN: 141501	From 10/01/2013 To 09/30/2014	Date/Time Prepared: 3/2/2015 11:13 am

		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	48,000	48,000	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		79,824	0	79,824	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	79,824	48,000	127,824	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2013
 To 09/30/2014

Worksheet K-4
 Part I
 Date/Time Prepared:
 3/2/2015 11:13 am

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	669,242	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	48,348	0	0	0	0	9.00
10.00	Nursing Care	924,046	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	201,558	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	153,996	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	141,186	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	42,744	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,181,120	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2013
 To 09/30/2014

Worksheet K-4
 Part I
 Date/Time Prepared:
 3/2/2015 11:13 am

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	Hospice I TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	669,242	669,242		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	48,348	21,402	69,750	9.00
10.00	Nursing Care	0	924,046	409,034	1,333,080	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	201,558	89,221	290,779	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	153,996	68,167	222,163	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	141,186	62,497	203,683	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	42,744	18,921	61,665	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	2,181,120		2,181,120	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-4
Part II
Date/Time Prepared:
3/2/2015 11:13 am

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2013
 To 09/30/2014

Worksheet K-4
 Part II
 Date/Time Prepared:
 3/2/2015 11:13 am

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-669,242	1,511,878	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	48,348	9.00
10.00	Nursing Care	0	924,046	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	201,558	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	153,996	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	141,186	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	42,744	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		669,242	39.00
40.00	Unit Cost Multiplier		0.442656	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period: From 10/01/2013

Worksheet K-5

Hospice CCN: 141501

To 09/30/2014

Part I
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
			BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIXT	NEW BUILDING & FIXT	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	69,750	0	0	0	0	4.00
5.00	Nursing Care	1,333,080	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	290,779	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	222,163	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	203,683	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	61,665	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,181,120	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2013
 To 09/30/2014

Worksheet K-5
 Part I
 Date/Time Prepared:
 3/2/2015 11:13 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	14TH STREET	MOB PHASE I	MVBLE EQUIP			
	1.04	1.05	2.00			
1.00 Administrative and General	0	0	48,879	72,366	121,245	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	65	69,815	4.00
5.00 Nursing Care	0	0	0	173,382	1,506,462	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	37,819	328,598	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	13,917	236,080	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	203,683	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	61,665	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	48,879	297,549	2,527,548	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2013
To 09/30/2014

Part I
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	34,613	0	3,579	22,872	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	19,931	0	0	0	0	4.00
5.00	Nursing Care	430,065	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	93,808	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	67,396	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	58,147	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specif y	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	17,604	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	721,564	0	3,579	22,872	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 140015	Period: From 10/01/2013	Worksheet K-5 Part I
		Hospice CCN: 141501	To 09/30/2014	Date/Time Prepared: 3/2/2015 11:13 am
Hospice I				

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES	
	11.00	13.00	16.00	20.00	21.00	
1.00 Administrative and General	90,995	370,343	0	41,706	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	90,995	370,343	0	41,706	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2013
To 09/30/2014

Part I
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Hospice I					
		INTERNS & RESIDENTS	PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	PARAMED PRGM-PHARMACY	
		SERVICES-OTHER PRGM COSTS	23.00	23.01	23.02	23.03	
	22.00						
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period: From 10/01/2013

Worksheet K-5

Hospice CCN: 141501

To 09/30/2014

Part I
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	685,353					1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	89,746	0	89,746	19,884	109,630	4.00
5.00	Nursing Care	1,936,527	0	1,936,527	429,065	2,365,592	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	422,406	0	422,406	93,590	515,996	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	303,476	0	303,476	67,239	370,715	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	261,830	0	261,830	58,012	319,842	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	79,269	0	79,269	17,563	96,832	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3,778,607	0	3,778,607		3,778,607	34.00
35.00	Unit Cost Multiplier (see instructions)				0.221564		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIXT (SQUARE FEET)	NEW BUILDING & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	MOB PHASE I (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.05	2.00	4.00				
1.00 Administrative and General	0	49,108	385,678	0	0	121,245	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	348	0	0	69,815	4.00
5.00 Nursing Care	0	0	924,046	0	0	1,506,462	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	201,558	0	0	328,598	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	74,172	0	0	236,080	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	203,683	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	61,665	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	49,108	1,585,802	0	0	2,527,548	34.00
35.00 Total cost to be allocated	0	48,879	297,549	0	0	721,564	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.995337	0.187633	0	0	0.285480	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Hospice I					
		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	3,132	648	0	9,944	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	3,132	648	0	9,944	34.00
35.00	Total cost to be allocated	0	3,579	22,872	0	90,995	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	1.142720	35.296296	0.000000	9.150744	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	HOSPICE I		
				INTERNS & RESIDENTS		
				SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
	13.00	16.00	20.00	21.00	22.00	
1.00 Administrative and General	61,898	0	265	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	61,898	0	265	0	0	34.00
35.00 Total cost to be allocated	370,343	0	41,706	0	0	35.00
36.00 Unit Cost Multiplier (see instructions)	5.983117	0.000000	157.381132	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
3/2/2015 11:13 am

Cost Center Description		Hospice I					
		PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)		
		23.00	23.01	23.02	23.03		
1.00	Administrative and General	0	0	0	0		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0		34.00
35.00	Total cost to be allocated	0	0	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 140015 Hospice CCN: 141501	Period: From 10/01/2013 To 09/30/2014	Worksheet K-5 Part III Date/Time Prepared: 3/2/2015 11:13 am	
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCI LLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.602259	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.407144	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.350885	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.205160	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.105687	0	0 6.00
6.01	BLOOD LABORATORY	60.01			6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.175616	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			9.00
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00			10.00
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2013
 To 09/30/2014

Worksheet K-6
 Date/Time Prepared:
 3/2/2015 11:13 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				3,778,607	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				15,695	2.00
3.00	Average cost per diem (line 1 divided by line 2)				240.75	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	14,283				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	3,438,632				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		680			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		163,710			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		3,991			10.00
11.00	Aggregate NF cost (line 3 times line 10)		960,833			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			732		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			176,229		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140015	Period: From 10/01/2013 To 09/30/2014	Worksheet L Parts I-III Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,009,283	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		116,370	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		103.50	3.00
4.00	Number of interns & residents (see instructions)		16.92	4.00
5.00	Indirect medical education percentage (see instructions)		4.72	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		142,038	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		3,267,691	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2013 To 09/30/2014	Worksheet M-1 Date/Time Prepared: 3/2/2015 11:13 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	160,610	0	160,610	0	160,610	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	166,440	0	166,440	0	166,440	9.00
10.00	Subtotal (sum of lines 1-9)	327,050	0	327,050	0	327,050	10.00
11.00	Physician Services Under Agreement	0	323,004	323,004	0	323,004	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	11,536	11,536	0	11,536	13.00
14.00	Subtotal (sum of lines 11-13)	0	334,540	334,540	0	334,540	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	47,049	47,049	-1,520	45,529	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	47,049	47,049	-1,520	45,529	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	327,050	381,589	708,639	-1,520	707,119	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	84,589	84,589	-41,705	42,884	29.00
30.00	Administrative Costs	93,343	71,530	164,873	0	164,873	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	93,343	156,119	249,462	-41,705	207,757	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	420,393	537,708	958,101	-43,225	914,876	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2013 To 09/30/2014	Worksheet M-1 Date/Time Prepared: 3/2/2015 11:13 am
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	160,610
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	166,440
10.00	Subtotal (sum of lines 1-9)	0	327,050
11.00	Physician Services Under Agreement	0	323,004
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	11,536
14.00	Subtotal (sum of lines 11-13)	0	334,540
15.00	Medical Supplies	0	0
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	45,529
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	45,529
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	707,119
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	42,884
30.00	Administrative Costs	0	164,873
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	207,757
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	914,876

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2013 To 09/30/2014	Worksheet M-2 Date/Time Prepared: 3/2/2015 11:13 am		
		Rural Health Clinic (RHC) I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.93	3,027	4,200	3,906	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.45	3,534	2,100	3,045	3.00
4.00	Subtotal (sum of lines 1-3)	2.38	6,561		6,951	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.38	6,561		6,951	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				707,119	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				707,119	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				207,757	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				363,212	15.00
16.00	Total overhead (sum of lines 14 and 15)				570,969	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				570,969	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				570,969	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,278,088	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140015	Period:	Worksheet M-3
		Component CCN: 143422	From 10/01/2013 To 09/30/2014	Date/Time Prepared: 3/2/2015 11:13 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,278,088	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		14,212	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,263,876	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		6,951	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,951	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		181.83	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	79.17	79.80	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	553	1,651	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	43,781	131,750	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	30	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	2,394	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	2,394	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		177,925	16.00
16.01	Total program charges (see instructions)(from contractor's records)		389,504	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		350	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		160	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		114,247	16.04
16.05	Total program cost (see instructions)		114,407	16.05
17.00	Primary payer amounts		138	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		34,956	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		70,910	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		114,269	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,024	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		120,293	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		120,293	26.00
26.01	Sequestration adjustment (see instructions)		2,406	26.01
27.00	Interim payments		144,631	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		-26,744	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140015
Component CCN: 143422

Period:
From 10/01/2013
To 09/30/2014

Worksheet M-4
Date/Time Prepared:
3/2/2015 11:13 am

Title XVIII

Rural Health
Clinic (RHC) I

Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	327,050	327,050	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000152	0.004877	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	50	1,595	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,830	4,388	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,880	5,983	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	707,119	707,119	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	570,969	570,969	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002659	0.008461	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,518	4,831	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,398	10,814	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	450	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	242.71	24.03	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	180	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,699	4,325	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		14,212	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		6,024	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2013 To 09/30/2014	Worksheet M-5 Date/Time Prepared: 3/2/2015 11:13 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		109,266	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01		05/30/2014	2,665	3.01
3.02		09/19/2014	32,700	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		35,365	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		144,631	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		26,744	6.02
7.00	Total Medicare program liability (see instructions)		117,887	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00