

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 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/26/2016 10:07 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input 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.	Date: 2/26/2016 Time: 10:07 pm
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 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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	632,174	209,654	32,285	0	1.00
2.00 Subprovider - IPF	0	169,678	-291		0	2.00
3.00 Subprovider - IRF	0	67,725	-107		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	411,882	-8,084		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		26,998		0	10.00
200.00 Total	0	1,281,459	228,170	32,285	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 8:50 pm				
1.00			2.00		3.00			4.00					
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 1005 BROADWAY				PO Box:				1.00				
2.00	City: QUINCY				State: IL		Zip Code: 62301		County: ADAMS				
	Component Name				CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
	1.00				2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:													
3.00	Hospital				BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF				BLESSING PSYCHIATRIC UNIT	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		O	N	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)								10/01/2014	09/30/2015	20.00		
21.00	Type of Control (see instructions)								2		21.00		
	Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.								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)								N	Y	22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.								N	N	22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								N	N	22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								3	N	23.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				5,138	0	673	0	492	0	24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.				451	0	83	0	0	0	25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 8:50 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		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.	10/01/2014	09/30/2015			36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0			37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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 Wkst. D, Parts III & IV and D-2, Pt. 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, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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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 Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs 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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
				1.00	2.00	3.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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.				109.00	
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00	
				1.00	2.00	
				3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	712,451	1,706,539		0118.01	
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		Y		118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		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.		Y		121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 8:50 pm	
		1.00	2.00		
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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 SRVICES		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	
				1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00	
				1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
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		165.00	
		Name	County	State	Zip Code
		0	1.00	2.00	3.00
		4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)			0.00	
				1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.01		169.00	
		Beginning		Ending	
		1.00		2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	12/08/2010		03/07/2011	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 8:50 pm	
				1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/26/2016 8:50 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		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.		Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
			Part A		Part B
			Description	Y/N	Date
			0	1.00	2.00
			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
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	12/31/2015	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-2
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

	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 10/01/2014
To 09/30/2015

Worksheet S-2
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		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)	12/31/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part IX Date/Time Prepared: 2/26/2016 8:50 pm	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

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	203	64,845	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)		203	64,845	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)		228	73,970	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	41	18,254		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)		307				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 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	21,320	4,114	34,610			1.00
2.00 HMO and other (see instructions)	2,854	329				2.00
3.00 HMO IPF Subprovider	159	674				3.00
4.00 HMO IRF Subprovider	297	0				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)	21,320	4,114	34,610			7.00
8.00 INTENSIVE CARE UNIT	2,732	602	5,015			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		1,258	2,360			13.00
14.00 Total (see instructions)	24,052	5,974	41,985	17.42	1,674.41	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,907	6,274	10,875	0.26	85.28	16.00
17.00 SUBPROVIDER - IRF	3,559	534	5,339	0.55	28.55	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	4,305	0	5,492	0.00	30.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	36,550	0	52,215	0.00	55.76	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	27.80	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	2,453	0	7,654	0.00	8.64	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				18.23	1,910.44	27.00
28.00 Observation Bed Days		0	8,143			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			783			30.00
31.00 Employee discount days - IRF			43			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 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5,433	1,638	10,323	1.00
2.00 HMO and other (see instructions)			626	138		2.00
3.00 HMO IPF Subprovider				87		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	5,433	1,638	10,323	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	282	1,005	1,837	16.00
17.00 SUBPROVIDER - IRF	0.00	0	247	35	371	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 10/01/2014 To 09/30/2015	Worksheet S-3 Part II Date/Time Prepared: 2/26/2016 8:50 pm		
	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	102,701,016	0	102,701,016	3,963,701.85	25.91	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		880,637	0	880,637	5,510.00	159.83	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		5,867,261	0	5,867,261	19,811.18	296.16	5.00
6.00	Non-physician-Part B		702,801	0	702,801	22,730.05	30.92	6.00
7.00	Interns & residents (in an approved program)	21.00	1,102,679	0	1,102,679	39,964.60	27.59	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	1,465,395	-14,939	1,450,456	61,807.47	23.47	9.00
10.00	Excluded area salaries (see instructions)		15,035,967	837,823	15,873,790	592,285.91	26.80	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		1,624,497	0	1,624,497	21,676.56	74.94	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		880,702	0	880,702	5,510.00	159.84	13.00
14.00	Home office salaries & wage-related costs		14,331,556	0	14,331,556	335,845.06	42.67	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)		39,762,498	0	39,762,498			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		8,463,643	0	8,463,643			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		237,487	0	237,487			22.00
22.01	Physician Part A - Teaching		1,464,548	0	1,464,548			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		316,936	0	316,936			24.00
25.00	Interns & residents (in an approved program)		527,058	0	527,058			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	2,399,542	0	2,399,542	154,960.11	15.48	26.00
27.00	Administrative & General	5.00	12,627,094	0	12,627,094	480,421.32	26.28	27.00
28.00	Administrative & General under contract (see inst.)		918,361	0	918,361	5,180.00	177.29	28.00
29.00	Maintenance & Repairs	6.00	2,396,030	0	2,396,030	115,562.86	20.73	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	64,811	0	64,811	5,243.16	12.36	31.00
32.00	Housekeeping	9.00	2,241,331	0	2,241,331	166,619.22	13.45	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,308,235	-1,638,847	669,388	53,183.67	12.59	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,638,847	1,638,847	130,208.30	12.59	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,390,909	-16,390	5,374,519	197,572.59	27.20	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 10/01/2014
To 09/30/2015

Worksheet S-3
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

	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)	Pai d Hours Rel ated to Sal ari es i n col . 4	Average Hourl y Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medi cal Records & Medi cal Records Li brary	16.00 490,023	0	490,023	26,658.87	18.38	41.00
42.00	Soci al Servi ce	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part III
Date/Time Prepared:
2/26/2016 8:50 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries 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)	95,946,636	0	95,946,636	3,886,376.02	24.69	1.00
2.00	Excluded area salaries (see instructions)	16,501,362	822,884	17,324,246	654,093.38	26.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)	79,445,274	-822,884	78,622,390	3,232,282.64	24.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	16,836,755	0	16,836,755	363,031.62	46.38	4.00
5.00	Subtotal wage-related costs (see inst.)	39,999,985	0	39,999,985	0.00	50.88	5.00
6.00	Total (sum of lines 3 thru 5)	136,282,014	-822,884	135,459,130	3,595,314.26	37.68	6.00
7.00	Total overhead cost (see instructions)	28,836,336	-16,390	28,819,946	1,335,610.10	21.58	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2016 8:50 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			3,100,334 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)			12,290,963 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)			25,074,468 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)			107,138 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)			221,881 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,402,724 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			7,426,680 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			80,142 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			1,067,840 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			50,772,170 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

WAGE INDEX PENSION COST SCHEDULE		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part IV Exhibit 3 Date/Time Prepared: 2/26/2016 8:50 pm
				1.00
Step 1: Determine the 3-Year Averaging Period				
1.00	Wage Index fiscal year ending.		2019	1.00
		From	To	
		1.00	2.00	
2.00	Provider cost reporting period used for Wage Index year shown on line 1.	10/01/2014	09/30/2015	2.00
3.00	Midpoint of provider's cost reporting period shown on line 2. (adjust response to first of month)	04/01/2015		3.00
4.00	Date beginning the 3-year averaging period. (subtract 18 months from midpoint shown on line 3)	10/01/2013		4.00
5.00	Date ending the of the 3-year averaging period. (add 18 months to midpoint shown on line 3)	09/30/2016		5.00
Step 2: Adjust Averaging Period for a New Plan(See Instructions) (Leave lines 6 through 8 blank if the provider has not elected to use an adjusted averaging period)				
6.00	Effective date of pension plan			6.00
7.00	First day of the provider cost reporting period containing the pension plan effective date.			7.00
8.00	Starting date of the adjusted averaging period. (date on line 7 if first of the month, otherwise to first of the month immediately preceding or following the date in line 7). If this date occurs after the period shown on line 2 (Step 1), stop here and see instructions. No cost is reportable for a period which is excluded from the averaging period.			8.00
Step 3: Average Pension Contribution During the Averaging Period				
9.00	Beginning date of averaging period from line 4 or line 8.	10/01/2013		9.00
10.00	Ending date of averaging period from line 5	09/30/2016		10.00
		Deposit Date	Contributions	
		1.00	2.00	
11.00	Enter provider contributions made during the averaging period shown on lines 9 & 10. Add additional lines as necessary if more than 15 contributions are made during the cost reporting period. (Data may be grouped within the averaging period to agree with documentation records (enter beginning date of grouped date range))			11.00
11.01			0	11.01
11.02			0	11.02
11.03			0	11.03
				1.00
12.00	Total number of months included in the averaging period		36	12.00
13.00	Total contributions made during averaging period		0	13.00
14.00	Average monthly contribution. (line 13 divided by line 12)		0	14.00
15.00	Number of months in provider cost reporting period shown on line 2.		12	15.00
16.00	Average pension contributions. (line 14 multiplied by line 15)		0	16.00
Step 4: Total Pension Cost for Wage Index				
17.00	Annual prefunding installment from line 8 of pension prefunding worksheet, if applicable.		0	17.00
18.00	Reportable prefunding installment. (line 17 multiplied by line 15 divided by 12)		0	18.00
19.00	Total Pension Cost for Wage Index. (line 16 plus line 18)		0	19.00
		Prepared By	Date	
		1.00	2.00	
Prepared By and Date Prepared				
100.00				100.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part V
Date/Time Prepared:
2/26/2016 8:50 pm

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	1,740,787	0	1.00
2.00	Hospital	1,624,497	0	2.00
3.00	Subprovider - IPF	108,136	0	3.00
4.00	Subprovider - IRF	2,065	0	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	6,089	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	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 10/01/2014 To 09/30/2015		Worksheet S-4 Date/Time Prepared: 2/26/2016 8:50 pm		
				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	8,369	0	1,769	10,138	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	1,122.00	0.00	769.00	1,891.00	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	0.00	3.00
4.00	Director(s) and Assistant Director(s)				1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel				9.43	0.00	9.43	5.00
6.00	Direct Nursing Service				25.38	0.00	25.38	6.00
7.00	Nursing Supervisor				0.00	0.00	0.00	7.00
8.00	Physical Therapy Service				9.77	0.00	9.77	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service				3.36	0.00	3.36	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00	11.00
12.00	Speech Pathology Service				0.52	0.00	0.52	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	0.00	13.00
14.00	Medical Social Service				1.43	0.00	1.43	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	15.00
16.00	Home Health Aide				4.87	0.00	4.87	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				4			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
20.02					31084			20.02
20.03					50089			20.03
		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	13,676	3,313	370	165	17,524	21.00	
22.00	Skilled Nursing Visit Charges	2,093,462	508,984	56,315	24,906	2,683,667	22.00	
23.00	Physical Therapy Visits	9,511	379	85	117	10,092	23.00	
24.00	Physical Therapy Visit Charges	1,452,304	58,317	13,083	17,843	1,541,547	24.00	
25.00	Occupational Therapy Visits	3,044	200	21	41	3,306	25.00	
26.00	Occupational Therapy Visit Charges	465,129	30,800	3,234	6,251	505,414	26.00	
27.00	Speech Pathology Visits	424	51	3	8	486	27.00	
28.00	Speech Pathology Visit Charges	65,065	7,854	462	1,232	74,613	28.00	
29.00	Medical Social Service Visits	71	2	2	1	76	29.00	
30.00	Medical Social Service Visit Charges	10,892	301	308	154	11,655	30.00	
31.00	Home Health Aide Visits	3,439	1,611	2	14	5,066	31.00	
32.00	Home Health Aide Visit Charges	294,860	138,150	172	1,148	434,330	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	30,165	5,556	483	346	36,550	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)	4,381,712	744,406	73,574	51,534	5,251,226	35.00	
36.00	Total Number of Episodes (standard/non outlier)	1,625		175	25	1,825	36.00	
37.00	Total Number of Outlier Episodes		93		1	94	37.00	
38.00	Total Non-Routine Medical Supply Charges	43,930	18,827	1,048	128	63,933	38.00	

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-7

Date/Time Prepared:
2/26/2016 8:50 pm

		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	11	0	11	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	52	0	52	7.00
8.00	RHL	127	0	127	8.00
9.00	RMX	104	0	104	9.00
10.00	RML	87	0	87	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	98	0	98	15.00
16.00	RVB	2	0	2	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	1,103	0	1,103	18.00
19.00	RHB	1,091	0	1,091	19.00
20.00	RHA	278	0	278	20.00
21.00	RMC	318	0	318	21.00
22.00	RMB	352	0	352	22.00
23.00	RMA	106	0	106	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	71	0	71	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	17	0	17	30.00
31.00	HD2	13	0	13	31.00
32.00	HD1	86	0	86	32.00
33.00	HC2	23	0	23	33.00
34.00	HC1	65	0	65	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	94	0	94	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	9	0	9	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	30	0	30	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	32	0	32	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	24	0	24	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	5	0	5	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	30	0	30	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	25	0	25	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	0	0	0	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 10/01/2014
To 09/30/2015

Worksheet S-7

Date/Time Prepared:
2/26/2016 8:50 pm

		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	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	11	0	11	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		4,305	0	4,305	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	1,465,395	30.38	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)	4,824,265			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2014 To 09/30/2015	Worksheet S-8 Date/Time Prepared: 2/26/2016 8:50 pm Cost	
		Rural Health Clinic (RHC) I		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	IL	62339
				1.00	
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0
		Grant Award		Date	
		1.00		2.00	
4.00		Source of Federal Funds			
5.00		Community Health Center (Section 330(d), PHS Act)		0	4.00
6.00		Migrant Health Center (Section 329(d), PHS Act)		0	5.00
7.00		Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00
8.00		Appalachian Regional Commission		0	7.00
9.00		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
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) Clinic		09:00	17:00	09:00
				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
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
				5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County		ADAMS		2.00
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
				Thursday	
				to	
				10.00	
11.00	Facility hours of operations (1) Clinic		17:00	08:00	17:00
				09:00	
				17:00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2014 To 09/30/2015	Worksheet S-8 Date/Time Prepared: 2/26/2016 8:50 pm	
			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 10/01/2014 To 09/30/2015	Worksheet S-9 Parts I & II Date/Time Prepared: 2/26/2016 8:50 pm
		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	14,591	285	7,810	73	655	15,531	2.00
3.00	Inpatient Respite Care	31	0	31	0	0	31	3.00
4.00	General Inpatient Care	201	24	200	24	19	244	4.00
5.00	Total Hospice Days	14,823	309	8,041	97	674	15,806	5.00
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	425	17	27	9	44	486	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)	34.88	18.18	297.81	10.78	15.32	32.52	8.00
9.00	Unduplicated Census Count	379	16	248	9	28	423	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet S-10 Date/Time Prepared: 2/26/2016 8:50 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.252283	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			21,698,067	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			6,608,535	5.00
6.00	Medicaid charges			169,942,611	6.00
7.00	Medicaid cost (line 1 times line 6)			42,873,632	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)			14,567,030	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)			14,567,030	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	16,940,343	153,309,392	170,249,735	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	4,273,761	38,677,353	42,951,114	21.00
22.00	Partial payment by patients approved for charity care	8,818	58,553	67,371	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,264,943	38,618,800	42,883,743	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)			10,718,711	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			1,396,364	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			9,322,347	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,351,870	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			45,235,613	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			59,802,643	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet A
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		5,050	5,050	23,142	1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIX		351,166	351,166	44,449	1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX		4,691,764	4,691,764	496,543	1.03
1.04	00104	CAP REL COSTS-14TH STREET		230,182	230,182	995,186	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I		0	0	92,657	1.05
1.06	00106	CAP REL COSTS-BBC		0	0	269,779	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP		13,101,437	13,101,437	310,730	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,399,542	53,336,202	55,735,744	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,627,094	67,378,033	80,005,127	-82,447	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,396,030	4,638,881	7,034,911	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,811	1,073,693	1,138,504	0	8.00
9.00	00900	HOUSEKEEPING	2,241,331	548,611	2,789,942	0	9.00
10.00	01000	DIETARY	2,308,235	3,599,077	5,907,312	-4,194,192	10.00
11.00	01100	CAFETERIA	0	0	0	4,194,192	11.00
13.00	01300	NURSING ADMINISTRATION	5,390,909	693,511	6,084,420	-16,439	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	490,023	3,121,162	3,611,185	0	16.00
20.00	02000	NURSING SCHOOL	3,214,036	1,428,747	4,642,783	857,385	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,102,679	0	1,102,679	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,112,445	2,112,445	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	258,111	9,523	267,634	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	60,906	5,997	66,903	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	217,891	13,566	231,457	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,351,224	2,149,600	16,500,824	-748,571	30.00
31.00	03100	INTENSIVE CARE UNIT	3,446,856	1,854,952	5,301,808	-275,894	31.00
40.00	04000	SUBPROVIDER - IPF	4,005,380	359,536	4,364,916	-26,751	40.00
41.00	04100	SUBPROVIDER - IRF	1,519,821	154,905	1,674,726	-17,928	41.00
43.00	04300	NURSERY	476,439	84,030	560,469	-74,760	43.00
44.00	04400	SKILLED NURSING FACILITY	1,465,395	128,767	1,594,162	-29,556	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,926,256	17,255,214	25,181,470	-12,459,372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,249,560	271,883	1,521,443	-108,041	52.00
53.00	05300	ANESTHESIOLOGY	167,186	552,689	719,875	-245,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,168,541	2,467,841	7,636,382	-301,701	54.00
60.00	06000	LABORATORY	3,014,875	3,205,993	6,220,868	-65,913	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	134,846	1,194,233	1,329,079	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,110,051	466,982	2,577,033	-142,128	65.00
66.00	06600	PHYSICAL THERAPY	1,337,368	29,736	1,367,104	-1,444	66.00
67.00	06700	OCCUPATIONAL THERAPY	552,827	7,526	560,353	-1,261	67.00
68.00	06800	SPEECH PATHOLOGY	270,923	7,345	278,268	-1,559	68.00
69.00	06900	ELECTROCARDIOLOGY	1,674,293	5,465,486	7,139,779	-4,720,753	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	313,998	71,947	385,945	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	655,553	940,124	1,595,677	6,552,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,940,022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,477,839	13,155,196	16,633,035	-67	73.00
74.00	07400	RENAL DIALYSIS	0	580,769	580,769	-268	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	476,332	588,705	1,065,037	-1,471	88.00
90.00	09000	CLINIC	344,095	113,004	457,099	-60	90.00
90.01	04950	OUTPATIENT INFUSION	53,728	13,342	67,070	-850	90.01
91.00	09100	EMERGENCY	9,976,210	1,073,158	11,049,368	-92,068	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,517,167	1,652,713	5,169,880	-2,205	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		2,181,149	2,181,149	-2,181,149	113.00
116.00	11600	HOSPICE	1,530,708	675,613	2,206,321	-351	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	101,989,069	213,041,485	315,030,554	-16,367	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	197,886	76,199	274,085	0	192.00
192.01	19201	FASTCARE	332,965	119,278	452,243	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	16,367	193.05
193.06	19306	RENTED SPACE	0	0	0	0	193.06

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015	Worksheet A Date/Time Prepared: 2/26/2016 8:50 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)
		1.00	2.00	3.00	4.00	5.00
193.07	19307 AUGUSTA PHARMACY	181,096	665,754	846,850	0	846,850
200.00	TOTAL (SUM OF LINES 118-199)	102,701,016	213,902,716	316,603,732	0	316,603,732

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet A
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	28,192	1.01
1.02	00102	CAP REL COSTS-OLD BUILDING & FIX	0	395,615	1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX	-702,845	4,485,462	1.03
1.04	00104	CAP REL COSTS-14TH STREET	-995,185	230,183	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	-71,951	20,706	1.05
1.06	00106	CAP REL COSTS-BBC	0	269,779	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-438,037	12,974,130	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-32,338,484	23,397,260	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-29,605,367	50,317,313	5.00
6.00	00600	MAINTENANCE & REPAIRS	-695,874	6,339,037	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-4,325	1,134,179	8.00
9.00	00900	HOUSEKEEPING	-294,531	2,495,411	9.00
10.00	01000	DIETARY	-1,107,329	605,791	10.00
11.00	01100	CAFETERIA	-1,482,226	2,711,966	11.00
13.00	01300	NURSING ADMINISTRATION	-249,796	5,818,185	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,640,833	970,352	16.00
20.00	02000	NURSING SCHOOL	-3,328,302	2,171,866	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,102,679	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,112,445	22.00
23.00	02300	PARAMED PRGM	0	0	23.00
23.01	02301	PARAMED PRGM-RADIOLOGY	-60,695	206,939	23.01
23.02	02302	PARAMED PRGM-LABORATORY	-22,800	44,103	23.02
23.03	02303	PARAMED PRGM-PHARMACY	0	231,457	23.03
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-24,832	15,727,421	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,431,735	3,594,179	31.00
40.00	04000	SUBPROVIDER - IPF	-4,499	4,333,666	40.00
41.00	04100	SUBPROVIDER - IRF	-13,874	1,642,924	41.00
43.00	04300	NURSERY	0	485,709	43.00
44.00	04400	SKILLED NURSING FACILITY	-878	1,563,728	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-473,388	12,248,710	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,413,402	52.00
53.00	05300	ANESTHESIOLOGY	0	474,126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,334,681	54.00
60.00	06000	LABORATORY	-65,590	6,089,365	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,329,079	62.00
65.00	06500	RESPIRATORY THERAPY	-22,270	2,412,635	65.00
66.00	06600	PHYSICAL THERAPY	-16,197	1,349,463	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	559,092	67.00
68.00	06800	SPEECH PATHOLOGY	0	276,709	68.00
69.00	06900	ELECTROCARDIOLOGY	-43,393	2,375,633	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-36,858	349,087	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,148,173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,940,022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,385,567	14,247,401	73.00
74.00	07400	RENAL DIALYSIS	0	580,501	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-74,884	988,682	88.00
90.00	09000	CLINIC	-420	456,619	90.00
90.01	04950	OUTPATIENT INFUSION	0	66,220	90.01
91.00	09100	EMERGENCY	-6,247,150	4,710,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-29,455	5,138,220	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-27,539	2,178,431	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-84,937,109	230,077,078	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	274,085	192.00
192.01	19201	FASTCARE	0	452,243	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	16,367	193.05
193.06	19306	RENTED SPACE	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	846,850	193.07
200.00		TOTAL (SUM OF LINES 118-199)	-84,937,109	231,666,623	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

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Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01 CAP REL COSTS-BUTLER BUILDING	00101		1.01
1.02 CAP REL COSTS-OLD BUILDING & FIX	00102		1.02
1.03 CAP REL COSTS-NEW BUILDING & FIX	00103		1.03
1.04 CAP REL COSTS-14TH STREET	00104		1.04
1.05 CAP REL COSTS-MOB PHASE I	00105		1.05
1.06 CAP REL COSTS-BBC	00106		1.06
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00 OTHER CAP REL COSTS	00300		3.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
20.00 NURSING SCHOOL	02000		20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	02100		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	02200		22.00
23.00 PARAMED PRGM	02300		23.00
23.01 PARAMED PRGM-RADIOLOGY	02301		23.01
23.02 PARAMED PRGM-LABORATORY	02302		23.02
23.03 PARAMED PRGM-PHARMACY	02303		23.03
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
41.00 SUBPROVIDER - IRF	04100		41.00
43.00 NURSERY	04300		43.00
44.00 SKILLED NURSING FACILITY	04400		44.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00 LABORATORY	06000		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
74.00 RENAL DIALYSIS	07400		74.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	08800		88.00
90.00 CLINIC	09000		90.00
90.01 OUTPATIENT INFUSION	04950		90.01
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
116.00 HOSPICE	11600		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01 FASTCARE	19201		192.01
193.00 NONPAID WORKERS	19300		193.00
193.02 DENMAN SERVICES	19302		193.02
193.03 MEALS ON WHEELS	19303		193.03
193.04 UNUSED SPACE	19304		193.04
193.05 HEALTH EDUCATION	19305		193.05
193.06 RENTED SPACE	19306		193.06

COST CENTERS USED IN COST REPORT		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet Non-CMS W Date/Time Prepared: 2/26/2016 8:50 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
193.07	AUGUSTA PHARMACY	1.00	2.00	
200.00	TOTAL (SUM OF LINES 118-199)	19307		193.07 200.00

RECLASSIFICATIONS

Provider CCN: 140015

Period:
From 10/01/2014
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	1,638,847	2,555,345	1.00
	TOTALS		1,638,847	2,555,345	
B - RECLASS C-SECTION COSTS					
1.00	OPERATING ROOM	50.00	10,565	0	1.00
	TOTALS		10,565	0	
C - RECLASS BBC RENT EXPENSE					
1.00	CAP REL COSTS-BBC	1.06	0	269,779	1.00
	TOTALS		0	269,779	
D - RECLASS CAPITAL RELATED INSURANCE					
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	23,142	1.00
2.00	CAP REL COSTS-OLD BUILDING & FIX	1.02	0	44,449	2.00
3.00	CAP REL COSTS-NEW BUILDING & FIX	1.03	0	64,204	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,336	4.00
	TOTALS		0	141,131	
F - RECLASS HEALTH EDUCATION					
1.00	HEALTH EDUCATION	193.05	16,318	49	1.00
	TOTALS		16,318	49	
G - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-NEW BUILDING & FIX	1.03	0	432,339	1.00
2.00	CAP REL COSTS-14TH STREET	1.04	0	995,186	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	301,394	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	452,230	4.00
	TOTALS		0	2,181,149	
H - RECLASS ER PHYSICIAN MALPRACTICE INS					
1.00	EMERGENCY	91.00	0	62,022	1.00
	TOTALS		0	62,022	
I - RECLASS CHARGABLE MEDICAL SUPPLEIS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,552,496	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,940,022	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
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		0	18,492,518	
J - RECLASS PRECEPTOR PAY					
1.00	NURSING SCHOOL	20.00	857,385	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
11.00		0.00	0	0	11.00
	TOTALS		857,385	0	

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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	K - RECLASS RENT EXPENSE				
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	92,657	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	92,657	
500.00	Grand Total: Increases		2,523,115	23,794,650	500.00

RECLASSIFICATIONS

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Period:
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		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	1,638,847	2,555,345	0		1.00
	TOTALS		1,638,847	2,555,345			
B - RECLASS C-SECTION COSTS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	10,565	0	0		1.00
	TOTALS		10,565	0			
C - RECLASS BBC RENT EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	269,779	10		1.00
	TOTALS		0	269,779			
D - RECLASS CAPITAL RELATED INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	141,131	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	141,131			
F - RECLASS HEALTH EDUCATION							
1.00	NURSING ADMINISTRATION	13.00	16,318	49	0		1.00
	TOTALS		16,318	49			
G - RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	2,181,149	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	0		4.00
	TOTALS		0	2,181,149			
H - RECLASS ER PHYSICIAN MALPRACTICE INS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,022	0		1.00
	TOTALS		0	62,022			
I - RECLASS CHARGABLE MEDICAL SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	266,465	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	144,187	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	1,379	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	7,420	0		4.00
5.00	NURSERY	43.00	0	46,942	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	14,617	0		6.00
7.00	OPERATING ROOM	50.00	0	12,355,529	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	84,637	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	245,749	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	301,701	0		10.00
11.00	LABORATORY	60.00	0	65,913	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	142,128	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,444	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	1,261	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	1,559	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	4,708,186	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	67	0		17.00
18.00	RENAL DIALYSIS	74.00	0	268	0		18.00
19.00	RURAL HEALTH CLINIC	88.00	0	1,471	0		19.00
20.00	CLINIC	90.00	0	60	0		20.00
21.00	OUTPATIENT INFUSION	90.01	0	850	0		21.00
22.00	EMERGENCY	91.00	0	98,129	0		22.00
23.00	HOME HEALTH AGENCY	101.00	0	2,205	0		23.00
24.00	HOSPICE	116.00	0	351	0		24.00
	TOTALS		0	18,492,518			
J - RECLASS PRECEPTOR PAY							
1.00	NURSING ADMINISTRATION	13.00	72	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	482,106	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	131,707	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	25,372	0	0		4.00
5.00	SUBPROVIDER - IRF	41.00	10,508	0	0		5.00
6.00	NURSERY	43.00	27,818	0	0		6.00
7.00	SKILLED NURSING FACILITY	44.00	14,939	0	0		7.00
8.00	OPERATING ROOM	50.00	83,496	0	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	12,839	0	0		9.00
10.00	ELECTROCARDIOLOGY	69.00	12,567	0	0		10.00
11.00	EMERGENCY	91.00	55,961	0	0		11.00
	TOTALS		857,385	0			
K - RECLASS RENT EXPENSE							
1.00	OPERATING ROOM	50.00	0	30,912	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	61,745	10		2.00
	TOTALS		0	92,657			
500.00	Grand Total: Decreases		2,523,115	23,794,650			500.00

RECLASSIFICATIONS

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From 10/01/2014
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Increases				Decreases					
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - RECLASS CAFETERIA COSTS									
1.00	CAFETERIA	11.00	1,638,847	2,555,345	DIETARY	10.00	1,638,847	2,555,345	1.00
	TOTALS		1,638,847	2,555,345	TOTALS		1,638,847	2,555,345	
B - RECLASS C-SECTION COSTS									
1.00	OPERATING ROOM	50.00	10,565	0	DELIVERY ROOM & LABOR ROOM	52.00	10,565	0	1.00
	TOTALS		10,565	0	TOTALS		10,565	0	
C - RECLASS BBC RENT EXPENSE									
1.00	CAP REL COSTS-BBC	1.06	0	269,779	ADMINISTRATIVE & GENERAL	5.00	0	269,779	1.00
	TOTALS		0	269,779	TOTALS		0	269,779	
D - RECLASS CAPITAL RELATED INSURANCE									
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	23,142	ADMINISTRATIVE & GENERAL	5.00	0	141,131	1.00
2.00	CAP REL COSTS-OLD BUILDING & FIX	1.02	0	44,449		0.00	0	0	2.00
3.00	CAP REL COSTS-NEW BUILDING & FIX	1.03	0	64,204		0.00	0	0	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,336		0.00	0	0	4.00
	TOTALS		0	141,131	TOTALS		0	141,131	
F - RECLASS HEALTH EDUCATION									
1.00	HEALTH EDUCATION	193.05	16,318	49	NURSING ADMINISTRATION	13.00	16,318	49	1.00
	TOTALS		16,318	49	TOTALS		16,318	49	
G - RECLASS INTEREST EXPENSE									
1.00	CAP REL COSTS-NEW BUILDING & FIX	1.03	0	432,339	INTEREST EXPENSE	113.00	0	2,181,149	1.00
2.00	CAP REL COSTS-14TH STREET	1.04	0	995,186		0.00	0	0	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	301,394		0.00	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	452,230		0.00	0	0	4.00
	TOTALS		0	2,181,149	TOTALS		0	2,181,149	
H - RECLASS ER PHYSICIAN MALPRACTICE INS									
1.00	EMERGENCY	91.00	0	62,022	ADMINISTRATIVE & GENERAL	5.00	0	62,022	1.00
	TOTALS		0	62,022	TOTALS		0	62,022	
I - RECLASS CHARGABLE MEDICAL SUPPLIES									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,552,496	ADULTS & PEDIATRICS	30.00	0	266,465	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	11,940,022	INTENSIVE CARE UNIT	31.00	0	144,187	2.00
3.00		0.00	0	0	SUBPROVIDER - I PF	40.00	0	1,379	3.00
4.00		0.00	0	0	SUBPROVIDER - I RF	41.00	0	7,420	4.00
5.00		0.00	0	0	NURSERY	43.00	0	46,942	5.00
6.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	14,617	6.00
7.00		0.00	0	0	OPERATING ROOM	50.00	0	12,355,529	7.00
8.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	84,637	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	245,749	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	301,701	10.00
11.00		0.00	0	0	LABORATORY	60.00	0	65,913	11.00
12.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	142,128	12.00
13.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	1,444	13.00
14.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	1,261	14.00
15.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	1,559	15.00
16.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	4,708,186	16.00
17.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	67	17.00
18.00		0.00	0	0	RENAL DIALYSIS	74.00	0	268	18.00
19.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	1,471	19.00
20.00		0.00	0	0	CLINIC	90.00	0	60	20.00
21.00		0.00	0	0	OUTPATIENT INFUSION	90.01	0	850	21.00
22.00		0.00	0	0	EMERGENCY	91.00	0	98,129	22.00
23.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	2,205	23.00
24.00		0.00	0	0	HOSPICE	116.00	0	351	24.00
	TOTALS		0	18,492,518	TOTALS		0	18,492,518	
J - RECLASS PRECEPTOR PAY									
1.00	NURSING SCHOOL	20.00	857,385	0	NURSING ADMINISTRATION	13.00	72	0	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	482,106	0	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	131,707	0	3.00

RECLASSIFICATIONS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

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	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
4.00		0.00	0		0 SUBPROVIDER - I PF	40.00	25,372	0	4.00
5.00		0.00	0		0 SUBPROVIDER - I RF	41.00	10,508	0	5.00
6.00		0.00	0		0 NURSERY	43.00	27,818	0	6.00
7.00		0.00	0		0 SKILLED NURSING FACILITY	44.00	14,939	0	7.00
8.00		0.00	0		0 OPERATING ROOM	50.00	83,496	0	8.00
9.00		0.00	0		0 DELIVERY ROOM & LABOR ROOM	52.00	12,839	0	9.00
10.00		0.00	0		0 ELECTROCARDIOLOGY	69.00	12,567	0	10.00
11.00		0.00	0		0 EMERGENCY	91.00	55,961	0	11.00
	TOTALS		857,385		0 TOTALS		857,385	0	
K - RECLASS RENT EXPENSE									
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	92,657	0 OPERATING ROOM	50.00	0	30,912	1.00
2.00		0.00	0		0 ADMINISTRATIVE & GENERAL	5.00	0	61,745	2.00
	TOTALS		0	92,657	0 TOTALS		0	92,657	
500.00	Grand Total : Increases		2,523,115	23,794,650	Grand Total : Decreases		2,523,115	23,794,650	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	12,900,770	282,254	0	282,254	0 1.00
2.00	Land Improvements	7,023,811	740,173	0	740,173	0 2.00
3.00	Buildings and Fixtures	104,303,320	36,576,677	0	36,576,677	0 3.00
4.00	Building Improvements	3,564,673	0	0	0	0 4.00
5.00	Fixed Equipment	38,726,112	34,657,496	0	34,657,496	0 5.00
6.00	Movable Equipment	160,488,259	23,370,119	-1,454,007	21,916,112	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	327,006,945	95,626,719	-1,454,007	94,172,712	0 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	327,006,945	95,626,719	-1,454,007	94,172,712	0 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	13,183,024	0			1.00
2.00	Land Improvements	7,763,984	0			2.00
3.00	Buildings and Fixtures	140,879,997	0			3.00
4.00	Building Improvements	3,564,673	0			4.00
5.00	Fixed Equipment	73,383,608	0			5.00
6.00	Movable Equipment	182,404,371	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	421,179,657	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	421,179,657	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	5,050	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIX	351,166	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIX	4,691,764	0	0	0	0	1.03
1.04	CAP REL COSTS-14TH STREET	230,182	0	0	0	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	13,101,437	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	18,379,599	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	5,050	1.01			
1.02	CAP REL COSTS-OLD BUILDING & FIX	0	351,166	1.02			
1.03	CAP REL COSTS-NEW BUILDING & FIX	0	4,691,764	1.03			
1.04	CAP REL COSTS-14TH STREET	0	230,182	1.04			
1.05	CAP REL COSTS-MOB PHASE I	0	0	1.05			
1.06	CAP REL COSTS-BBC	0	0	1.06			
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,101,437	2.00			
3.00	Total (sum of lines 1-2)	0	18,379,599	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	307,247	0	307,247	0.000768	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIX	156,605,889	0	156,605,889	0.391287	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIX	44,863,922	0	44,863,922	0.112095	0	1.03
1.04	CAP REL COSTS-14TH STREET	16,051,221	0	16,051,221	0.040105	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0.000000	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	182,404,371	0	182,404,371	0.455745	0	2.00
3.00	Total (sum of lines 1-2)	400,232,650	0	400,232,650	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of col. 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	5,050	0	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIX	0	0	0	351,166	0	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIX	0	0	0	4,765,541	0	1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	230,182	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	20,706	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0	269,779	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	12,989,451	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	18,341,390	290,485	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 col. 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	23,142	0	0	28,192	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIX	0	44,449	0	0	395,615	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIX	-344,283	64,204	0	0	4,485,462	1.03
1.04	CAP REL COSTS-14TH STREET	1	0	0	0	230,183	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	20,706	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0	269,779	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	-24,657	9,336	0	0	12,974,130	2.00
3.00	Total (sum of lines 1-2)	-368,939	141,131	0	0	18,404,067	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8

Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			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 & FIX (chapter 2)			OCAP REL COSTS-OLD BUILDING & FIX	1.02	0 1.02
1.03 Investment income - CAP REL COSTS-NEW BUILDING & FIX (chapter 2)			OCAP REL COSTS-NEW BUILDING & FIX	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
1.06 Investment income - CAP REL COSTS-BBC (chapter 2)			OCAP REL COSTS-BBC	1.06	0 1.06
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	-634,906	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	-199,912	ADMINISTRATIVE & GENERAL	5.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-58,639	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	-21,003,880			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	9,686,661			0 12.00
13.00 Laundry and linen service			0	0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-1,482,226	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	-2,250,575	DRUGS CHARGED TO PATIENTS	73.00	0 17.00
18.00 Sale of medical records and abstracts	B	-101,469	MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)	B	-3,257,810	NURSING SCHOOL	20.00	0 19.00
20.00 Vending machines	B	-11,718	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		ORESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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

ADJUSTMENTS TO EXPENSES

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8

Date/Time Prepared:
2/26/2016 8:50 pm

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	2.00	3.00	4.00	5.00
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING			OCAP REL COSTS-BUTLER BUILDING	1.01	0 26.01
26.02	Depreciation - CAP REL COSTS-OLD BUILDING & FIX			OCAP REL COSTS-OLD BUILDING & FIX	1.02	0 26.02
26.03	Depreciation - CAP REL COSTS-NEW BUILDING & FIX			OCAP REL COSTS-NEW BUILDING & FIX	1.03	0 26.03
26.04	Depreciation - CAP REL COSTS-14TH STREET			OCAP REL COSTS-14TH STREET	1.04	0 26.04
26.05	Depreciation - CAP REL COSTS-MOB PHASE I			OCAP REL COSTS-MOB PHASE I	1.05	0 26.05
26.06	Depreciation - CAP REL COSTS-BBC			OCAP REL COSTS-BBC	1.06	0 26.06
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant			0	0.00	0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00	30.00
30.99	Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00	30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0 32.00
33.00	RENTAL INSURANCE EXPENSE	A	-9,313	ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01	DAMAGED GOODS	B	-14,411	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02	CHILD CARE CENTER	B	-1,780,633	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.02
33.03	BOOKKEEPING FEES	B	-147,524	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04	RADIOLOGY TUITION	B	-60,695	PARAMED ED PRGM-RADIOLOGY	23.01	0 33.04
33.05	PRINT SHOP	B	-70,879	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06	HEALTH PROMOTIONS	B	-110,514	NURSING ADMINISTRATION	13.00	0 33.06
33.07	HOUSEKEEPING SERVICES	B	-294,531	HOUSEKEEPING	9.00	0 33.07
33.08	ADVERTISING	A	-298,831	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09	RENTAL PROPERTY EXPENSE	A	-24,658	CAP REL COSTS-MVBLE EQUIP	2.00	11 33.09
33.10	REAL ESTATE TAXES ON RENTAL	A	-97,819	MAINTENANCE & REPAIRS	6.00	0 33.10
33.11	RENTAL PROPERTY EXPENSE	A	-75,943	MAINTENANCE & REPAIRS	6.00	0 33.11
33.12	INTERST INCOME	A	-432,339	CAP REL COSTS-NEW BUILDING & FIX	1.03	11 33.12
33.13	INTEREST INCOME	A	-995,185	CAP REL COSTS-14TH STREET	1.04	11 33.13
33.14	INTEREST INCOME	A	-301,393	CAP REL COSTS-MVBLE EQUIP	2.00	11 33.14
33.15	INTEREST INCOME	A	-452,230	ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.16	DIETARY OUTSIDE SERVICES-SALARIES	A	-44,281	DIETARY	10.00	0 33.16
33.17	DIETARY OUTSIDE SERVICES-BENEFITS	A	-21,937	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.17
33.18	PHYSICIAN RECRUITMENT	A	-516,116	ADMINISTRATIVE & GENERAL	5.00	0 33.18
33.19	NURSING SCHOOL ADVERTISING	A	-26,384	NURSING SCHOOL	20.00	0 33.19
33.20	LOBBYING EXPENSE	A	-51,007	ADMINISTRATIVE & GENERAL	5.00	0 33.20
33.21	TRANSFER TO PARENT	A	-6,041,401	ADMINISTRATIVE & GENERAL	5.00	0 33.21
33.22	HOSPICE PROFESSIONAL FEES	A	-27,539	HOSPICE	116.00	0 33.22
33.23	HOME CARE PROFESSIONAL FEES	A	-600	HOME HEALTH AGENCY	101.00	0 33.23
33.24	HOME CARE PROFESSIONAL FEES	A	-10,000	HOME HEALTH AGENCY	101.00	0 33.24
33.25	ER PHYSICIAN BENEFITS	A	-1,057,023	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.25
33.26	ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	0 33.26
33.27	BOOK TO MEDICARE DEPRECIATION	A	73,777	CAP REL COSTS-NEW BUILDING & FIX	1.03	9 33.27
33.28	GROUND FEES	B	-69,963	MAINTENANCE & REPAIRS	6.00	0 33.28
33.29	LABORATORY TUITION	B	-22,800	PARAMED ED PRGM-LABORATORY	23.02	0 33.29
33.30	CV SURGEON BENEFITS	A	-51,247	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.30
33.31	SELF-FUNDED HEALTH INSURANCE	A	-19,413,181	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.31
33.32	LEASED EQUIPMENT	B	-10,641	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.32
33.33	STUDER GROUP EXPENSE	A	-178,526	ADMINISTRATIVE & GENERAL	5.00	0 33.33
33.34	TRAUMA ON-CALL	A	-1,160,636	ADMINISTRATIVE & GENERAL	5.00	0 33.34
33.35	NON-HOSPITAL DEPRECIATION	A	-42,706	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.35
33.36	MISCELLANEOUS INCOME	B	-64,965	ADMINISTRATIVE & GENERAL	5.00	0 33.36
33.37	MISCELLANEOUS INCOME	B	-1,800	OPERATING ROOM	50.00	0 33.37
33.38	MISCELLANEOUS INCOME	B	-11,953	RESPIRATORY THERAPY	65.00	0 33.38
33.39	MISCELLANEOUS INCOME	B	-31,542	ELECTROENCEPHALOGRAPHY	70.00	0 33.39

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	
33.40	MI SCCELLANEOUS INCOME	B	-12,415	ADMINISTRATIVE & GENERAL	5.00	0 33.40
33.41	MI SCCELLANEOUS INCOME	B	-618,027	ADMINISTRATIVE & GENERAL	5.00	0 33.41
33.42	MI SCCELLANEOUS INCOME	B	-5,590	LABORATORY	60.00	0 33.42
33.43	MI SCCELLANEOUS INCOME	B	-50,600	DRUGS CHARGED TO PATIENTS	73.00	0 33.43
33.44	MI SCCELLANEOUS INCOME	B	-19,971	ELECTROCARDIOLOGY	69.00	0 33.44
33.45	MI SCCELLANEOUS INCOME	B	-16,197	PHYSICAL THERAPY	66.00	0 33.45
33.46	MI SCCELLANEOUS INCOME	B	-50,635	MEDICAL RECORDS & LIBRARY	16.00	0 33.46
33.47	CARE COORDINATION	B	-113,317	ADMINISTRATIVE & GENERAL	5.00	0 33.47
33.48	MI SCCELLANEOUS INCOME	B	-76,272	ADMINISTRATIVE & GENERAL	5.00	0 33.48
33.49	MI SCCELLANEOUS INCOME	B	-22,428	ADMINISTRATIVE & GENERAL	5.00	0 33.49
33.50	MI SCCELLANEOUS INCOME	B	-12,204	ADMINISTRATIVE & GENERAL	5.00	0 33.50
33.51	MI SCCELLANEOUS INCOME	B	-420	CLINIC	90.00	0 33.51
33.52	MI SCCELLANEOUS INCOME	B	-30,750	ADMINISTRATIVE & GENERAL	5.00	0 33.52
33.53	CATERING REVENUE	B	-226,119	DIETARY	10.00	0 33.53
33.54	FLOOR STOCK REVENUE	B	-247,000	DIETARY	10.00	0 33.54
33.55	CHILD CARE CENTER SERVICES	B	-217,259	DIETARY	10.00	0 33.55
33.56	OUTSIDE CATERING	B	-2,769	DIETARY	10.00	0 33.56
33.57	BH JAVA	B	-358,183	DIETARY	10.00	0 33.57
33.58	BPS EXPENSES	A	-16,178,875	ADMINISTRATIVE & GENERAL	5.00	0 33.58
33.59	ECHO OUTREACH SALARIES	A	-12,655	ELECTROCARDIOLOGY	69.00	0 33.59
33.60	ECHO OUTREACH BENEFITS	A	-6,269	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.60
33.61	PHARMACY COVERAGE SALARIES	A	-44,805	DRUGS CHARGED TO PATIENTS	73.00	0 33.61
33.62	PHARMACY COVERAGE BENEFITS	A	-22,196	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.62
33.63	PHARMACY COVERAGE EXPENSES	A	-28,037	DRUGS CHARGED TO PATIENTS	73.00	0 33.63
33.64	INFORMATION SYSTEMS WAGES	A	-4,384,288	ADMINISTRATIVE & GENERAL	5.00	0 33.64
33.65	INFORMATION SYSTEMS BENEFITS	A	-2,232,444	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.65
33.66	PAIN MANAGEMENT-NP SALARIES	A	-58,215	OPERATING ROOM	50.00	0 33.66
33.67	PAIN MANAGEMENT-NP BENEFITS	A	-28,840	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.67
33.68	NP AND PA IN URGENT CARE SALARIES	A	-168,253	EMERGENCY	91.00	0 33.68
33.69	NP AND PA IN URGENT CARE BENEFITS	A	-83,353	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.69
33.70	COLLEGE OF NURSING LOBBYING	A	-44,108	NURSING SCHOOL	20.00	0 33.70
33.71	BCS ALLOCATIONS	A	-1,256,214	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.71
33.72	BCS ALLOCATIONS	A	-2,172,626	ADMINISTRATIVE & GENERAL	5.00	0 33.72
33.73	BCS ALLOCATIONS	A	-2,441,581	MEDICAL RECORDS & LIBRARY	16.00	0 33.73
33.74	BCS ALLOCATIONS	A	-20,250	OPERATING ROOM	50.00	0 33.74
33.75	BCS ALLOCATIONS	A	-31,788	RURAL HEALTH CLINIC	88.00	0 33.75
33.76	BCS ALLOCATIONS	A	-18,855	HOME HEALTH AGENCY	101.00	0 33.76
33.77	MI SCCELLANEOUS INCOME	A	-11,550	DRUGS CHARGED TO PATIENTS	73.00	0 33.77
33.78	MI SCCELLANEOUS INCOME	A	-625	NURSING ADMINISTRATION	13.00	0 33.78
33.79	RENTAL PROPERTY EXPENSE	A	-344,283	CAP REL COSTS-NEW BUILDING & FIX	1.03	11 33.79
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-84,937,109			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 10/01/2014 To 09/30/2015

Worksheet A-8-1

Date/Time Prepared: 2/26/2016 8:50 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	6.00	MAINTENANCE & REPAIRS	BIO-MED	520,214	972,363	1.00
2.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	1,050,639	1,054,964	2.00
3.00	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	31,963	75,059	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	24,470,055	7,365,064	4.00
4.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	-6,235,518	0	4.01
4.02	1.05	CAP REL COSTS-MOB PHASE I	SURGERY RENT	7,900	30,912	4.02
4.03	1.05	CAP REL COSTS-MOB PHASE I	CARE COORDINATION RENT	12,806	61,745	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	PFS AND PT ACCESS COSTS	0	269,526	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	PFS AND PT ACCESS BENEFITS	0	60,706	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	0	4,648	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	ACCOUNTS PAYABLE BENEFITS	0	2,303	4.07
4.08	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS COSTS	0	47,148	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	MEDICAL RECORDS BENEFITS	0	9,789	4.09
4.10	13.00	NURSING ADMINISTRATION	INFORMATICS/CARE MGMT COSTS	0	138,657	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	INFORMATICS/CARE MGMT BENEFIT	0	67,958	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	ABSTRACTING COSTS	0	7,059	4.12
4.13	4.00	EMPLOYEE BENEFITS DEPARTMENT	ABSTRACTING BENEFITS	0	3,497	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			19,858,059	10,171,398	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 10/01/2014
To 09/30/2015

Worksheet A-8-1

Date/Time Prepared:
2/26/2016 8:50 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-452,149	0	1.00
2.00	-4,325	0	2.00
3.00	-43,096	0	3.00
4.00	17,104,991	0	4.00
4.01	-6,235,518	0	4.01
4.02	-23,012	10	4.02
4.03	-48,939	10	4.03
4.04	-269,526	0	4.04
4.05	-60,706	0	4.05
4.06	-4,648	0	4.06
4.07	-2,303	0	4.07
4.08	-47,148	0	4.08
4.09	-9,789	0	4.09
4.10	-138,657	0	4.10
4.11	-67,958	0	4.11
4.12	-7,059	0	4.12
4.13	-3,497	0	4.13
5.00	9,686,661		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 requested 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 10/01/2014
To 09/30/2015

Worksheet A-8-2

Date/Time Prepared:
2/26/2016 8:50 pm

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours		
1.00	2.00	3.00	4.00	5.00	6.00	7.00		
1.00	5.00	ADMI NISTRATI VE & GENERAL	1,932,942	1,822,182	110,760	159,800	759	1.00
2.00	5.00	ADMI NISTRATI VE & GENERAL	93,053	0	93,053	208,000	730	2.00
3.00	5.00	ADMI NISTRATI VE & GENERAL	2,031,071	2,031,071	0	0	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	5,376	5,376	0	0	0	4.00
5.00	30.00	ADULTS & PEDI ATRICS	21,985	0	21,985	159,800	154	5.00
6.00	30.00	ADULTS & PEDI ATRICS	19,825	0	19,825	159,800	67	6.00
7.00	31.00	INTENSI VE CARE UNI T	1,312,255	1,312,255	0	0	0	7.00
8.00	31.00	INTENSI VE CARE UNI T	119,480	119,480	0	0	0	8.00
9.00	40.00	SUBPROVI DER - IPF	8,100	0	8,100	138,700	54	9.00
10.00	41.00	SUBPROVI DER - IRF	36,000	0	36,000	159,800	288	10.00
11.00	44.00	SKI LLED NURSI NG FACI LITY	1,800	0	1,800	159,800	12	11.00
12.00	50.00	OPERATI NG ROOM	26,000	0	26,000	159,800	130	12.00
13.00	60.00	LABORATORY	60,000	60,000	0	0	0	13.00
14.00	65.00	RESPI RATORY THERAPY	10,650	0	10,650	159,800	71	14.00
15.00	65.00	RESPI RATORY THERAPY	10,500	0	10,500	159,800	70	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	11,594	0	11,594	159,800	93	16.00
17.00	69.00	ELECTROCARDI OLOGY	7,540	0	7,540	159,800	58	17.00
18.00	69.00	ELECTROCARDI OLOGY	18,675	0	18,675	182,900	125	18.00
19.00	70.00	ELECTROENCEPHALOGRAPHY	2,250	0	2,250	159,800	18	19.00
20.00	91.00	EMERGENCY	31,200	0	31,200	159,800	240	20.00
21.00	91.00	EMERGENCY	216,384	148,384	68,000	159,800	340	21.00
22.00	91.00	EMERGENCY	5,568,352	5,568,352	0	0	0	22.00
23.00	91.00	EMERGENCY	312,505	0	312,505	159,800	1,988	23.00
24.00	91.00	EMERGENCY	147,748	147,748	0	0	0	24.00
25.00	50.00	OPERATI NG ROOM	15,525	15,525	0	0	0	25.00
26.00	50.00	OPERATI NG ROOM	90,265	0	90,265	182,900	313	26.00
27.00	5.00	ADMI NISTRATI VE & GENERAL	9,038,512	9,038,512	0	0	0	27.00
28.00	50.00	OPERATI NG ROOM	298,844	298,844	0	0	0	28.00
200.00			21,448,431	20,567,729	880,702		5,510	200.00

Wkst. A Line #	Cost Center/Physician Identifier	Unadj usted RCE Li mi t	5 Percent of Unadj usted RCE Li mi t	Cost of Memberships & Conti nui ng Educati on	Provider Component Share of col . 12	Physi ci an Cost of Malpracti ce Insurance		
1.00	2.00	8.00	9.00	12.00	13.00	14.00		
1.00	5.00	ADMI NISTRATI VE & GENERAL	58,312	2,916	0	0	0	1.00
2.00	5.00	ADMI NISTRATI VE & GENERAL	73,000	3,650	0	0	0	2.00
3.00	5.00	ADMI NISTRATI VE & GENERAL	0	0	0	0	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDI ATRICS	11,831	592	0	0	0	5.00
6.00	30.00	ADULTS & PEDI ATRICS	5,147	257	0	0	0	6.00
7.00	31.00	INTENSI VE CARE UNI T	0	0	0	0	0	7.00
8.00	31.00	INTENSI VE CARE UNI T	0	0	0	0	0	8.00
9.00	40.00	SUBPROVI DER - IPF	3,601	180	0	0	0	9.00
10.00	41.00	SUBPROVI DER - IRF	22,126	1,106	0	0	0	10.00
11.00	44.00	SKI LLED NURSI NG FACI LITY	922	46	0	0	0	11.00
12.00	50.00	OPERATI NG ROOM	9,988	499	0	0	0	12.00
13.00	60.00	LABORATORY	0	0	0	0	0	13.00
14.00	65.00	RESPI RATORY THERAPY	5,455	273	0	0	0	14.00
15.00	65.00	RESPI RATORY THERAPY	5,378	269	0	0	0	15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	7,145	357	0	0	0	16.00
17.00	69.00	ELECTROCARDI OLOGY	4,456	223	0	0	0	17.00
18.00	69.00	ELECTROCARDI OLOGY	10,992	550	0	0	0	18.00
19.00	70.00	ELECTROENCEPHALOGRAPHY	1,383	69	0	0	0	19.00
20.00	91.00	EMERGENCY	18,439	922	0	0	0	20.00
21.00	91.00	EMERGENCY	26,121	1,306	0	0	0	21.00
22.00	91.00	EMERGENCY	0	0	0	0	0	22.00
23.00	91.00	EMERGENCY	152,732	7,637	0	0	0	23.00
24.00	91.00	EMERGENCY	0	0	0	0	0	24.00
25.00	50.00	OPERATI NG ROOM	0	0	0	0	0	25.00
26.00	50.00	OPERATI NG ROOM	27,523	1,376	0	0	0	26.00
27.00	5.00	ADMI NISTRATI VE & GENERAL	0	0	0	0	0	27.00
28.00	50.00	OPERATI NG ROOM	0	0	0	0	0	28.00
200.00			444,551	22,228	0	0	0	200.00

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col . 14	Adj usted RCE Li mi t	RCE Di sal lowance	Adj ustment		
1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMI NISTRATI VE & GENERAL	0	58,312	52,448	1,874,630	1.00
2.00	5.00	ADMI NISTRATI VE & GENERAL	0	73,000	20,053	20,053	2.00
3.00	5.00	ADMI NISTRATI VE & GENERAL	0	0	0	2,031,071	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	5,376	4.00
5.00	30.00	ADULTS & PEDI ATRICS	0	11,831	10,154	10,154	5.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8-2

Date/Time Prepared:
2/26/2016 8:50 pm

	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		
6.00	30.00	ADULTS & PEDIATRICS	0	5,147	14,678	14,678		6.00
7.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,312,255		7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	119,480		8.00
9.00	40.00	SUBPROVIDER - IPF	0	3,601	4,499	4,499		9.00
10.00	41.00	SUBPROVIDER - IRF	0	22,126	13,874	13,874		10.00
11.00	44.00	SKILLED NURSING FACILITY	0	922	878	878		11.00
12.00	50.00	OPERATING ROOM	0	9,988	16,012	16,012		12.00
13.00	60.00	LABORATORY	0	0	0	60,000		13.00
14.00	65.00	RESPIRATORY THERAPY	0	5,455	5,195	5,195		14.00
15.00	65.00	RESPIRATORY THERAPY	0	5,378	5,122	5,122		15.00
16.00	70.00	ELECTROENCEPHALOGRAPHY	0	7,145	4,449	4,449		16.00
17.00	69.00	ELECTROCARDIOLOGY	0	4,456	3,084	3,084		17.00
18.00	69.00	ELECTROCARDIOLOGY	0	10,992	7,683	7,683		18.00
19.00	70.00	ELECTROENCEPHALOGRAPHY	0	1,383	867	867		19.00
20.00	91.00	EMERGENCY	0	18,439	12,761	12,761		20.00
21.00	91.00	EMERGENCY	0	26,121	41,879	190,263		21.00
22.00	91.00	EMERGENCY	0	0	0	5,568,352		22.00
23.00	91.00	EMERGENCY	0	152,732	159,773	159,773		23.00
24.00	91.00	EMERGENCY	0	0	0	147,748		24.00
25.00	50.00	OPERATING ROOM	0	0	0	15,525		25.00
26.00	50.00	OPERATING ROOM	0	27,523	62,742	62,742		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	298,844		28.00
200.00			0	444,551	436,151	21,003,880		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIX	NEW BUILDING & FIX	
		0	1.00	1.01	1.02	
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	28,192	0	28,192	0	1.01
1.02 00102	CAP REL COSTS-OLD BUILDING & FIX	395,615	0	0	395,615	1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIX	4,485,462	0	0	0	4,485,462
1.04 00104	CAP REL COSTS-14TH STREET	230,183	0	0	0	0
1.05 00105	CAP REL COSTS-MOB PHASE I	20,706	0	0	0	0
1.06 00106	CAP REL COSTS-BBC	269,779	0	0	0	0
2.00 00200	CAP REL COSTS-MVBLE EQUIP	12,974,130	0	0	0	0
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	23,397,260	0	0	20,583	44,249
5.00 00500	ADMINISTRATIVE & GENERAL	50,317,313	0	0	87,473	816,987
6.00 00600	MAINTENANCE & REPAIRS	6,339,037	0	5,938	58,295	560,189
8.00 00800	LAUNDRY & LINEN SERVICE	1,134,179	0	0	5,595	6,871
9.00 00900	HOUSEKEEPING	2,495,411	0	0	13,042	4,562
10.00 01000	DIETARY	605,791	0	0	0	106,646
11.00 01100	CAFETERIA	2,711,966	0	0	0	47,821
13.00 01300	NURSING ADMINISTRATION	5,818,185	0	0	12,799	3,967
16.00 01600	MEDICAL RECORDS & LIBRARY	970,352	0	0	3,576	65,567
20.00 02000	NURSING SCHOOL	2,171,866	0	22,254	0	194,932
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,102,679	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,112,445	0	0	0	0
23.00 02300	PARAMED PRGM	0	0	0	0	0
23.01 02301	PARAMED PRGM-RADIOLOGY	206,939	0	0	0	4,727
23.02 02302	PARAMED PRGM-LABORATORY	44,103	0	0	0	4,727
23.03 02303	PARAMED PRGM-PHARMACY	231,457	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	15,727,421	0	0	2,714	918,237
31.00 03100	INTENSIVE CARE UNIT	3,594,179	0	0	32,973	106,215
40.00 04000	SUBPROVIDER - IPF	4,333,666	0	0	0	111,318
41.00 04100	SUBPROVIDER - IRF	1,642,924	0	0	16,328	50,698
43.00 04300	NURSERY	485,709	0	0	0	32,678
44.00 04400	SKILLED NURSING FACILITY	1,563,728	0	0	0	87,068
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	12,248,710	0	0	35,926	237,687
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,413,402	0	0	21,375	19,064
53.00 05300	ANESTHESIOLOGY	474,126	0	0	1,975	6,211
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,334,681	0	0	0	306,653
60.00 06000	LABORATORY	6,089,365	0	0	2,176	98,584
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,329,079	0	0	0	3,527
65.00 06500	RESPIRATORY THERAPY	2,412,635	0	0	5,997	0
66.00 06600	PHYSICAL THERAPY	1,349,463	0	0	0	31,377
67.00 06700	OCCUPATIONAL THERAPY	559,092	0	0	0	15,043
68.00 06800	SPEECH PATHOLOGY	276,709	0	0	0	5,094
69.00 06900	ELECTROCARDIOLOGY	2,375,633	0	0	26,813	41,418
70.00 07000	ELECTROENCEPHALOGRAPHY	349,087	0	0	6,875	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,148,173	0	0	0	39,686
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	11,940,022	0	0	0	72,328
73.00 07300	DRUGS CHARGED TO PATIENTS	14,247,401	0	0	1,013	35,023
74.00 07400	RENAL DIALYSIS	580,501	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	988,682	0	0	0	0
90.00 09000	CLINIC	456,619	0	0	0	0
90.01 04950	OUTPATIENT INFUSION	66,220	0	0	0	10,673
91.00 09100	EMERGENCY	4,710,150	0	0	25,143	153,725
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	5,138,220	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
116.00 11600	HOSPICE	2,178,431	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	230,077,078	0	28,192	380,671	4,243,552
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,249	7,274
192.00 19200	PHYSICIANS' PRIVATE OFFICES	274,085	0	0	0	0
192.01 19201	FASTCARE	452,243	0	0	0	0
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.02 19302	DENMAN SERVICES	0	0	0	0	9,161
193.03 19303	MEALS ON WHEELS	0	0	0	0	0
193.04 19304	UNUSED SPACE	0	0	0	3,840	57,651

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
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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 & FIX	NEW BUILDING & FIX	
		1.00	1.01	1.02	1.03	
193.05 19305 HEALTH EDUCATION	16,367	0	0	0	0	193.05
193.06 19306 RENTED SPACE	0	0	0	1,855	167,824	193.06
193.07 19307 AUGUSTA PHARMACY	846,850	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)	231,666,623	0	28,192	395,615	4,485,462	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	4.00
		14TH STREET	MOB PHASE I	BBC	MVBLE EQUIP		
		1.04	1.05	1.06	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 & FIX					1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX					1.03
1.04	00104	CAP REL COSTS-14TH STREET	230,183				1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	20,706			1.05
1.06	00106	CAP REL COSTS-BBC	0	0	269,779		1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP				12,974,130	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	489	0	0	112,559	23,575,140
5.00	00500	ADMINISTRATIVE & GENERAL	53,967	12,806	198,102	4,707,087	2,147,384
6.00	00600	MAINTENANCE & REPAIRS	54,623	0	4,165	272,018	633,987
8.00	00800	LAUNDRY & LINEN SERVICE	335	0	0	4,100	17,149
9.00	00900	HOUSEKEEPING	2,342	0	0	94,789	593,054
10.00	01000	DIETARY	2,953	0	0	111,658	165,403
11.00	01100	CAFETERIA	3,797	0	0	0	433,637
13.00	01300	NURSING ADMINISTRATION	3,354	0	26,886	833,883	1,385,795
16.00	01600	MEDICAL RECORDS & LIBRARY	1,085	0	40,626	211,689	124,431
20.00	02000	NURSING SCHOOL	6,789	0	0	18,217	1,077,294
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	291,768
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	390	0
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
23.01	02301	PARAMED ED PRGM-RADIOLOGY	232	0	0	0	68,296
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	1,333	16,116
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	57,654
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	490,105	3,669,757
31.00	03100	INTENSIVE CARE UNIT	0	0	0	79,729	877,185
40.00	04000	SUBPROVIDER - IPF	14,269	0	0	15,738	1,053,106
41.00	04100	SUBPROVIDER - IRF	0	0	0	28,611	399,363
43.00	04300	NURSERY	0	0	0	15,946	118,705
44.00	04400	SKILLED NURSING FACILITY	0	0	0	278	383,789
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	7,900	0	1,911,486	1,983,504
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	40,298	324,440
53.00	05300	ANESTHESIOLOGY	0	0	0	166,734	44,237
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,326,112	1,367,591
60.00	06000	LABORATORY	299	0	0	227,845	797,733
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	355	35,680
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	558,317
66.00	06600	PHYSICAL THERAPY	0	0	0	6,876	353,866
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,061	146,277
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,617	71,686
69.00	06900	ELECTROCARDIOLOGY	36	0	0	627,617	436,343
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	41,631	83,084
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,229	0	0	40,890	61,456
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,708	0	0	74,522	112,002
73.00	07300	DRUGS CHARGED TO PATIENTS	291	0	0	275,058	908,377
74.00	07400	RENAL DIALYSIS	0	0	0	7,604	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	126,037
90.00	09000	CLINIC	0	0	0	0	91,047
90.01	04950	OUTPATIENT INFUSION	0	0	0	0	14,216
91.00	09100	EMERGENCY	6,900	0	0	102,083	1,024,300
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	4,384	0	0	7,249	930,639
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	98,252	397,737
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,082	20,706	269,779	12,960,420	23,382,442
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,980	0	0	1,223	52,360
192.01	19201	FASTCARE	0	0	0	12,202	88,102
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	DENMAN SERVICES	1,691	0	0	285	0
193.03	19303	MEALS ON WHEELS	0	0	0	0	0
193.04	19304	UNUSED SPACE	38,765	0	0	0	0
193.05	19305	HEALTH EDUCATION	0	0	0	0	4,318
193.06	19306	RENTED SPACE	7,335	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
			14TH STREET	MOB PHASE I	BBC	MVBLE EQUIP		
			1.04	1.05	1.06	2.00		
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	47,918	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)	230,183	20,706	269,779	12,974,130	23,575,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	6.00	8.00	9.00	
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 & FIX						1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	58,341,119	58,341,119				5.00
6.00	00600	MAINTENANCE & REPAIRS	7,928,252	2,668,642	10,596,894			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,168,229	393,225	54,922	1,616,376		8.00
9.00	00900	HOUSEKEEPING	3,203,200	1,078,194	137,559	3,662	4,422,615	9.00
10.00	01000	DIETARY	992,451	334,058	282,813	13,614	55,247	10.00
11.00	01100	CAFETERIA	3,197,221	1,076,181	179,341	0	141,697	11.00
13.00	01300	NURSING ADMINISTRATION	8,084,869	2,721,359	165,767	0	63,648	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,417,326	477,071	194,050	0	47,790	16.00
20.00	02000	NURSING SCHOOL	3,491,352	1,175,186	817,208	0	126,782	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,394,447	469,369	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,112,835	711,178	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	280,194	94,313	14,690	0	2,614	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	66,279	22,309	9,755	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	289,111	97,314	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,808,234	7,003,958	1,911,276	578,246	1,119,261	30.00
31.00	03100	INTENSIVE CARE UNIT	4,690,281	1,578,744	417,424	102,394	321,626	31.00
40.00	04000	SUBPROVIDER - I PF	5,528,097	1,860,752	532,787	75,519	289,695	40.00
41.00	04100	SUBPROVIDER - I RF	2,137,924	719,623	202,785	58,450	112,423	41.00
43.00	04300	NURSERY	653,038	219,812	67,437	9,309	29,617	43.00
44.00	04400	SKILLED NURSING FACILITY	2,034,863	684,933	179,682	47,660	104,880	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	16,425,213	5,528,710	735,326	207,974	532,372	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,818,579	612,132	167,847	42,409	117,438	52.00
53.00	05300	ANESTHESIOLOGY	693,283	233,358	24,691	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,335,037	3,815,362	632,837	143,357	214,946	54.00
60.00	06000	LABORATORY	7,216,002	2,428,899	222,882	334	79,249	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,368,641	460,683	7,279	0	1,286	62.00
65.00	06500	RESPIRATORY THERAPY	2,976,949	1,002,038	36,054	812	88,207	65.00
66.00	06600	PHYSICAL THERAPY	1,741,582	586,215	64,753	94	68,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	724,473	243,857	31,044	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	357,106	120,202	10,512	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,507,860	1,180,742	247,441	47,353	33,603	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	480,677	161,795	41,328	5,020	16,073	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,294,434	2,791,898	171,722	7,932	29,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,206,582	4,108,723	312,968	13,459	50,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,467,163	5,206,232	84,547	0	39,046	73.00
74.00	07400	RENAL DIALYSIS	588,105	197,956	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,114,719	375,213	0	0	771	88.00
90.00	09000	CLINIC	547,666	184,344	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	91,109	30,667	22,025	0	0	90.01
91.00	09100	EMERGENCY	6,022,301	2,027,100	614,952	249,017	393,975	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	6,080,492	2,046,688	93,112	0	157,856	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,674,420	900,207	0	4,043	27,774	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	229,551,715	57,629,242	8,688,816	1,610,658	4,266,817	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,853	6,346	120,109	5,718	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	339,648	114,325	254,455	0	0	192.00
192.01	19201	FASTCARE	552,547	185,987	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	11,137	3,749	54,827	0	26,745	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	100,256	33,746	965,411	0	0	193.04
193.05	19305	HEALTH EDUCATION	20,685	6,963	0	0	0	193.05
193.06	19306	RENTED SPACE	177,014	59,583	513,276	0	129,053	193.06
193.07	19307	AUGUSTA PHARMACY	894,768	301,178	0	0	0	193.07
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140015			Period: From 10/01/2014 To 09/30/2015		Worksheet B Part I Date/Time Prepared: 2/26/2016 8:50 pm	
Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
202.00	TOTAL (sum lines 118-201)	231,666,623	58,341,119	10,596,894	1,616,376	4,422,615	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet B Part I Date/Time Prepared: 2/26/2016 8:50 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	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 & FIX						1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
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	1,678,183					10.00
11.00	01100	CAFETERIA	0	4,594,440				11.00
13.00	01300	NURSING ADMINISTRATION	0	316,783	11,352,426			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	43,579	0	2,179,816		16.00
20.00	02000	NURSING SCHOOL	0	246,514	0	0	5,857,042	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	65,697	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	13,699	0	0	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	3,442	0	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	8,994	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	951,317	915,883	3,808,691	1,227,907	3,880,870	30.00
31.00	03100	INTENSIVE CARE UNIT	136,391	202,036	840,146	176,056	312,225	31.00
40.00	04000	SUBPROVIDER - I/PF	296,018	289,023	1,201,875	382,096	353,186	40.00
41.00	04100	SUBPROVIDER - I/RF	144,877	96,788	402,480	187,003	9,404	41.00
43.00	04300	NURSERY	0	23,420	97,383	4,016	64,786	43.00
44.00	04400	SKILLED NURSING FACILITY	149,580	101,614	422,551	193,077	522,465	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	483,427	2,010,301	0	183,490	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	71,794	298,555	0	189,132	52.00
53.00	05300	ANESTHESIOLOGY	0	12,699	52,804	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	311,604	0	0	0	54.00
60.00	06000	LABORATORY	0	240,396	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9,893	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	129,738	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	60,528	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28,235	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,174	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	93,639	0	0	21,944	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	24,137	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,549	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,394	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	157,034	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	20,412	0	0	50,993	90.00
90.01	04950	OUTPATIENT INFUSION	0	3,392	0	0	0	90.01
91.00	09100	EMERGENCY	0	236,671	984,174	9,661	251,828	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	0	190,680	792,942	0	9,404	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	94,376	392,472	0	7,315	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,678,183	4,584,244	11,304,374	2,179,816	5,857,042	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	9,166	0	0	0	192.00
192.01	19201	FASTCARE	0	0	48,052	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	1,030	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	0	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
		10.00	11.00	13.00	16.00	20.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,678,183	4,594,440	11,352,426	2,179,816	5,857,042	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	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 & FIX					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIX					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05
1.06 00106	CAP REL COSTS-BBC					1.06
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	1,863,816				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		2,889,710			22.00
23.00 02300	PARAMED PRGM			0		23.00
23.01 02301	PARAMED PRGM-RADIOLOGY				405,510	23.01
23.02 02302	PARAMED PRGM-LABORATORY					23.02
23.03 02303	PARAMED PRGM-PHARMACY					23.03
					101,785	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,190,914	1,846,425	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	92,271	143,059	0	0	31.00
40.00 04000	SUBPROVIDER - I PF	36,891	57,197	0	0	40.00
41.00 04100	SUBPROVIDER - I RF	78,042	120,999	0	0	41.00
43.00 04300	NURSERY	34,080	52,838	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	93,719	145,304	0	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	9,968	15,455	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	22,748	35,269	0	405,510	54.00
60.00 06000	LABORATORY	11,331	17,569	0	0	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	83,751	129,849	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	88,011	136,454	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	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 04950	OUTPATIENT INFUSION	0	0	0	0	90.01
91.00 09100	EMERGENCY	122,090	189,292	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)	1,863,816	2,889,710	0	405,510	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,863,816	2,889,710	0	405,510	101,785	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
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Cost Center Description			PARAMED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.03	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 & FIX					1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX					1.03
1.04	00104	CAP REL COSTS-14TH STREET					1.04
1.05	00105	CAP REL COSTS-MOB PHASE I					1.05
1.06	00106	CAP REL COSTS-BBC					1.06
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 PRGM					23.00
23.01	02301	PARAMED PRGM-RADIOLOGY					23.01
23.02	02302	PARAMED PRGM-LABORATORY					23.02
23.03	02303	PARAMED PRGM-PHARMACY	395,419				23.03
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	45,242,982	-3,037,339	42,205,643	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,012,653	-235,330	8,777,323	31.00
40.00	04000	SUBPROVIDER - I PF	0	10,903,136	-94,088	10,809,048	40.00
41.00	04100	SUBPROVIDER - I RF	0	4,270,798	-199,041	4,071,757	41.00
43.00	04300	NURSERY	0	1,255,736	-86,918	1,168,818	43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,441,305	0	4,441,305	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	26,345,836	-239,023	26,106,813	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,317,886	0	3,317,886	52.00
53.00	05300	ANESTHESIOLOGY	0	1,042,258	-25,423	1,016,835	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,916,670	-58,017	16,858,653	54.00
60.00	06000	LABORATORY	0	10,318,447	-28,900	10,289,547	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,847,782	0	1,847,782	62.00
65.00	06500	RESPIRATORY THERAPY	0	4,233,798	0	4,233,798	65.00
66.00	06600	PHYSICAL THERAPY	0	2,522,135	0	2,522,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,027,609	0	1,027,609	67.00
68.00	06800	SPEECH PATHOLOGY	0	500,994	0	500,994	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,346,182	-213,600	5,132,582	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	953,495	-224,465	729,030	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,322,195	0	11,322,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,740,444	0	16,740,444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	395,419	21,349,441	0	21,349,441	73.00
74.00	07400	RENAL DIALYSIS	0	786,061	0	786,061	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,490,703	0	1,490,703	88.00
90.00	09000	CLINIC	0	803,415	0	803,415	90.00
90.01	04950	OUTPATIENT INFUSION	0	147,193	0	147,193	90.01
91.00	09100	EMERGENCY	0	11,101,061	-311,382	10,789,679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	9,371,174	0	9,371,174	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	4,100,607	0	4,100,607	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	395,419	226,711,996	-4,753,526	221,958,470	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	151,026	0	151,026	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	717,594	0	717,594	192.00
192.01	19201	FASTCARE	0	786,586	0	786,586	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	96,458	0	96,458	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	1,099,413	0	1,099,413	193.04
193.05	19305	HEALTH EDUCATION	0	28,678	0	28,678	193.05
193.06	19306	RENTED SPACE	0	878,926	0	878,926	193.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

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Cost Center Description			PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.03	24.00	25.00	26.00	
193.07	19307	AUGUSTA PHARMACY	0	1,195,946	0	1,195,946	193.07
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	395,419	231,666,623	-4,753,526	226,913,097	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet Non-CMS W
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	31	SQUARE FEET	1.01
1.02	CAP REL COSTS-OLD BUILDING & FIX	32	SQUARE FEET	1.02
1.03	CAP REL COSTS-NEW BUILDING & FIX	33	SQUARE FEET	1.03
1.04	CAP REL COSTS-14TH STREET	34	SQUARE FEET	1.04
1.05	CAP REL COSTS-MOB PHASE I	35	SQUARE FEET	1.05
1.06	CAP REL COSTS-BBC	36	SQUARE FEET	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	7	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00
20.00	NURSING SCHOOL	20	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	21	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	21	ASSIGNED TIME	22.00
23.00	PARAMED ED PRGM	23	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

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 & FIX	NEW BUILDING & FIX	
			1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS		0					
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
1.06	00106						1.06
2.00	00200						2.00
4.00	00400	5,208	0	0	20,583	44,249	4.00
5.00	00500	99,146	0	0	87,473	816,987	5.00
6.00	00600	1,372	0	5,938	58,295	560,189	6.00
8.00	00800	0	0	0	5,595	6,871	8.00
9.00	00900	0	0	0	13,042	4,562	9.00
10.00	01000	8,264	0	0	0	106,646	10.00
11.00	01100	0	0	0	0	47,821	11.00
13.00	01300	20,204	0	0	12,799	3,967	13.00
16.00	01600	1,095	0	0	3,576	65,567	16.00
20.00	02000	7,950	0	22,254	0	194,932	20.00
21.00	02100	0	0	0	0	0	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	780	0	0	0	4,727	23.01
23.02	02302	0	0	0	0	4,727	23.02
23.03	02303	0	0	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	91,934	0	0	2,714	918,237	30.00
31.00	03100	32,890	0	0	32,973	106,215	31.00
40.00	04000	12,586	0	0	0	111,318	40.00
41.00	04100	2,333	0	0	16,328	50,698	41.00
43.00	04300	0	0	0	0	32,678	43.00
44.00	04400	12,288	0	0	0	87,068	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,002,536	0	0	35,926	237,687	50.00
52.00	05200	0	0	0	21,375	19,064	52.00
53.00	05300	15,665	0	0	1,975	6,211	53.00
54.00	05400	417,720	0	0	0	306,653	54.00
60.00	06000	151,143	0	0	2,176	98,584	60.00
62.00	06200	0	0	0	0	3,527	62.00
65.00	06500	81,803	0	0	5,997	0	65.00
66.00	06600	0	0	0	0	31,377	66.00
67.00	06700	16	0	0	0	15,043	67.00
68.00	06800	0	0	0	0	5,094	68.00
69.00	06900	300	0	0	26,813	41,418	69.00
70.00	07000	36,987	0	0	6,875	0	70.00
71.00	07100	59,747	0	0	0	39,686	71.00
72.00	07200	108,887	0	0	0	72,328	72.00
73.00	07300	0	0	0	1,013	35,023	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	33,174	0	0	0	0	88.00
90.00	09000	65,998	0	0	0	0	90.00
90.01	04950	0	0	0	0	10,673	90.01
91.00	09100	2,460	0	0	25,143	153,725	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	6,574	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	145,455	0	0	0	0	116.00
118.00		2,424,515	0	28,192	380,671	4,243,552	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	44,824	0	0	9,249	7,274	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	74,436	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
193.02	19302	0	0	0	0	9,161	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	3,840	57,651	193.04
193.05	19305	0	0	0	0	0	193.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIX	NEW BUILDING & FIX	
		1.00	1.01	1.02	1.03	
193.06 19306 RENTED SPACE	0	0	0	1,855	167,824	193.06
193.07 19307 AUGUSTA PHARMACY	0	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)	2,543,775	0	28,192	395,615	4,485,462	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 2/26/2016 8:50 pm
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Cost Center Description		CAPITAL RELATED COSTS				Subtotal 2A		
		14TH STREET	MOB PHASE I	BBC	MVBLE EQUIP			
		1.04	1.05	1.06	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 & FIX					1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX					1.03	
1.04	00104	CAP REL COSTS-14TH STREET					1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I					1.05	
1.06	00106	CAP REL COSTS-BBC					1.06	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	489	0	0	112,559	183,088	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,967	12,806	198,102	4,707,087	5,975,568	5.00
6.00	00600	MAINTENANCE & REPAIRS	54,623	0	4,165	272,018	956,600	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	335	0	0	4,100	16,901	8.00
9.00	00900	HOUSEKEEPING	2,342	0	0	94,789	114,735	9.00
10.00	01000	DIETARY	2,953	0	0	111,658	229,521	10.00
11.00	01100	CAFETERIA	3,797	0	0	0	51,618	11.00
13.00	01300	NURSING ADMINISTRATION	3,354	0	26,886	833,883	901,093	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,085	0	40,626	211,689	323,638	16.00
20.00	02000	NURSING SCHOOL	6,789	0	0	18,217	250,142	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	390	390	22.00
23.00	02300	PARAMED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED PRGM-RADIOLOGY	232	0	0	0	5,739	23.01
23.02	02302	PARAMED PRGM-LABORATORY	0	0	0	1,333	6,060	23.02
23.03	02303	PARAMED PRGM-PHARMACY	0	0	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	490,105	1,502,990	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	79,729	251,807	31.00
40.00	04000	SUBPROVIDER - IPF	14,269	0	0	15,738	153,911	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	28,611	97,970	41.00
43.00	04300	NURSERY	0	0	0	15,946	48,624	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	278	99,634	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,900	0	1,911,486	3,195,535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	40,298	80,737	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	166,734	190,585	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,326,112	3,050,485	54.00
60.00	06000	LABORATORY	299	0	0	227,845	480,047	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	355	3,882	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	87,800	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,876	38,253	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,061	19,120	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,617	8,711	68.00
69.00	06900	ELECTROCARDIOLOGY	36	0	0	627,617	696,184	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	41,631	85,493	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,229	0	0	40,890	144,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,708	0	0	74,522	263,445	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	291	0	0	275,058	311,385	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,604	7,604	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	33,174	88.00
90.00	09000	CLINIC	0	0	0	0	65,998	90.00
90.01	04950	OUTPATIENT INFUSION	0	0	0	0	10,673	90.01
91.00	09100	EMERGENCY	6,900	0	0	102,083	290,311	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	4,384	0	0	7,249	18,207	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	98,252	243,707	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,082	20,706	269,779	12,960,420	20,495,917	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	0	0	0	63,677	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,980	0	0	1,223	13,203	192.00
192.01	19201	FASTCARE	0	0	0	12,202	86,638	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	1,691	0	0	285	11,137	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	38,765	0	0	0	100,256	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	7,335	0	0	0	177,014	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments					0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		CAPITAL RELATED COSTS				Subtotal 2A	
		14TH STREET	MOB PHASE I	BBC	MVBLE EQUIP		
		1.04	1.05	1.06	2.00		
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	230,183	20,706	269,779	12,974,130	20,947,842	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 2/26/2016 8:50 pm			
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
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 & FIX					1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX					1.03	
1.04	00104	CAP REL COSTS-14TH STREET					1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I					1.05	
1.06	00106	CAP REL COSTS-BBC					1.06	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	183,088				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	16,678	5,992,246			5.00	
6.00	00600	MAINTENANCE & REPAIRS	4,924	274,096	1,235,620		6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	133	40,388	6,404	63,826	8.00	
9.00	00900	HOUSEKEEPING	4,606	110,741	16,040	145	246,267	9.00
10.00	01000	DIETARY	1,285	34,311	32,977	538	3,076	10.00
11.00	01100	CAFETERIA	3,368	110,534	20,912	0	7,890	11.00
13.00	01300	NURSING ADMINISTRATION	10,763	279,510	19,329	0	3,544	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	966	49,000	22,627	0	2,661	16.00
20.00	02000	NURSING SCHOOL	8,367	120,703	95,288	0	7,060	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,266	48,209	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	73,045	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	530	9,687	1,713	0	146	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	125	2,291	1,138	0	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	448	9,995	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,491	719,419	222,858	22,832	62,325	30.00
31.00	03100	INTENSIVE CARE UNIT	6,813	162,152	48,672	4,043	17,909	31.00
40.00	04000	SUBPROVIDER - IPF	8,179	191,117	62,124	2,982	16,131	40.00
41.00	04100	SUBPROVIDER - IRF	3,102	73,912	23,645	2,308	6,260	41.00
43.00	04300	NURSERY	922	22,577	7,863	368	1,649	43.00
44.00	04400	SKILLED NURSING FACILITY	2,981	70,349	20,951	1,882	5,840	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,405	567,852	85,741	8,212	29,644	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,520	62,872	19,571	1,675	6,539	52.00
53.00	05300	ANESTHESIOLOGY	344	23,968	2,879	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,621	391,875	73,790	5,661	11,969	54.00
60.00	06000	LABORATORY	6,196	249,472	25,988	13	4,413	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	277	47,317	849	0	72	62.00
65.00	06500	RESPIRATORY THERAPY	4,336	102,919	4,204	32	4,912	65.00
66.00	06600	PHYSICAL THERAPY	2,748	60,210	7,550	4	3,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,136	25,046	3,620	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	557	12,346	1,226	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,389	121,274	28,852	1,870	1,871	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	645	16,618	4,819	198	895	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	477	286,755	20,023	313	1,652	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	870	422,006	36,493	531	2,802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,055	534,731	9,858	0	2,174	73.00
74.00	07400	RENAL DIALYSIS	0	20,332	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	979	38,538	0	0	43	88.00
90.00	09000	CLINIC	707	18,934	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	110	3,150	2,568	0	0	90.01
91.00	09100	EMERGENCY	7,955	208,203	71,705	9,833	21,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	7,228	210,215	10,857	0	8,790	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,089	92,460	0	160	1,547	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	181,591	5,919,129	1,013,134	63,600	237,592	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	652	14,005	226	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	407	11,742	29,670	0	0	192.00
192.01	19201	FASTCARE	684	19,103	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	385	6,393	0	1,489	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	3,466	112,569	0	0	193.04
193.05	19305	HEALTH EDUCATION	34	715	0	0	0	193.05
193.06	19306	RENTED SPACE	0	6,120	59,849	0	7,186	193.06
193.07	19307	AUGUSTA PHARMACY	372	30,934	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140015			Period: From 10/01/2014 To 09/30/2015		Worksheet B Part II Date/Time Prepared: 2/26/2016 8:50 pm	
Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT 4.00	ADMINISTRATIVE & GENERAL 5.00	MAINTENANCE & REPAIRS 6.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	183,088	5,992,246	1,235,620	63,826	246,267		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet B Part II Date/Time Prepared: 2/26/2016 8:50 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	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 & FIX						1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
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	301,708					10.00
11.00	01100	CAFETERIA	0	194,322				11.00
13.00	01300	NURSING ADMINISTRATION	0	13,398	1,227,637			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,843	0	400,735		16.00
20.00	02000	NURSING SCHOOL	0	10,426	0	0	491,986	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	2,779	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	579	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	146	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	380	0	0		23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	171,030	38,737	411,869	225,737		30.00
31.00	03100	INTENSIVE CARE UNIT	24,521	8,545	90,852	32,366		31.00
40.00	04000	SUBPROVIDER - IPF	53,219	12,224	129,969	70,244		40.00
41.00	04100	SUBPROVIDER - IRF	26,046	4,094	43,524	34,379		41.00
43.00	04300	NURSERY	0	991	10,531	738		43.00
44.00	04400	SKILLED NURSING FACILITY	26,892	4,298	45,694	35,495		44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,447	217,391	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,037	32,285	0		52.00
53.00	05300	ANESTHESIOLOGY	0	537	5,710	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,179	0	0		54.00
60.00	06000	LABORATORY	0	10,168	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	418	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	5,487	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,560	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,194	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	557	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,960	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,021	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,123	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,047	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,642	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	863	0	0		90.00
90.01	04950	OUTPATIENT INFUSION	0	143	0	0		90.01
91.00	09100	EMERGENCY	0	10,010	106,427	1,776		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	8,065	85,748	0		101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0		113.00
116.00	11600	HOSPICE	0	3,992	42,441	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	301,708	193,890	1,222,441	400,735	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	388	0	0		192.00
192.01	19201	FASTCARE	0	0	5,196	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	44	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					491,986	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
		10.00	11.00	13.00	16.00	20.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	301,708	194,322	1,227,637	400,735	491,986	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	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 & FIX					1.02
1.03 00103	CAP REL COSTS-NEW BUILDING & FIX					1.03
1.04 00104	CAP REL COSTS-14TH STREET					1.04
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05
1.06 00106	CAP REL COSTS-BBC					1.06
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	50,475				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		76,214			22.00
23.00 02300	PARAMED PRGM			0		23.00
23.01 02301	PARAMED PRGM-RADIOLOGY				18,394	23.01
23.02 02302	PARAMED PRGM-LABORATORY					23.02
23.03 02303	PARAMED PRGM-PHARMACY					23.03
23.03 02303	PARAMED PRGM-PHARMACY				9,760	23.03
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
90.01 04950	OUTPATIENT INFUSION					90.01
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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
			21.00	22.00				
193.07	19307	AUGUSTA PHARMACY						193.07
200.00		Cross Foot Adjustments	50,475	76,214	0	18,394	9,760	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	50,475	76,214	0	18,394	9,760	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		PARAMED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.03	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 & FIX				1.02	
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX				1.03	
1.04	00104	CAP REL COSTS-14TH STREET				1.04	
1.05	00105	CAP REL COSTS-MOB PHASE I				1.05	
1.06	00106	CAP REL COSTS-BBC				1.06	
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 PRGM				23.00	
23.01	02301	PARAMED PRGM-RADIOLOGY				23.01	
23.02	02302	PARAMED PRGM-LABORATORY				23.02	
23.03	02303	PARAMED PRGM-PHARMACY	10,823			23.03	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,406,288	0	3,406,288	30.00	
31.00	03100	INTENSIVE CARE UNIT	647,680	0	647,680	31.00	
40.00	04000	SUBPROVIDER - I PF	700,100	0	700,100	40.00	
41.00	04100	SUBPROVIDER - I RF	315,240	0	315,240	41.00	
43.00	04300	NURSERY	94,263	0	94,263	43.00	
44.00	04400	SKILLED NURSING FACILITY	314,016	0	314,016	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,140,227	0	4,140,227	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,236	0	209,236	52.00	
53.00	05300	ANESTHESIOLOGY	224,023	0	224,023	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,557,580	0	3,557,580	54.00	
60.00	06000	LABORATORY	776,297	0	776,297	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	52,815	0	52,815	62.00	
65.00	06500	RESPIRATORY THERAPY	209,690	0	209,690	65.00	
66.00	06600	PHYSICAL THERAPY	115,165	0	115,165	66.00	
67.00	06700	OCCUPATIONAL THERAPY	50,116	0	50,116	67.00	
68.00	06800	SPEECH PATHOLOGY	23,397	0	23,397	68.00	
69.00	06900	ELECTROCARDIOLOGY	857,400	0	857,400	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	109,689	0	109,689	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,895	0	454,895	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	728,194	0	728,194	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	871,845	0	871,845	73.00	
74.00	07400	RENAL DIALYSIS	27,936	0	27,936	74.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	72,734	0	72,734	88.00	
90.00	09000	CLINIC	86,502	0	86,502	90.00	
90.01	04950	OUTPATIENT INFUSION	16,644	0	16,644	90.01	
91.00	09100	EMERGENCY	728,158	0	728,158	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	349,110	0	349,110	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE				113.00	
116.00	11600	HOSPICE	387,396	0	387,396	116.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	19,526,636	0	19,526,636	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,560	0	78,560	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	55,410	0	55,410	192.00	
192.01	19201	FASTCARE	111,621	0	111,621	192.01	
193.00	19300	NONPAID WORKERS	0	0	0	193.00	
193.02	19302	DENMAN SERVICES	19,404	0	19,404	193.02	
193.03	19303	MEALS ON WHEELS	0	0	0	193.03	
193.04	19304	UNUSED SPACE	216,291	0	216,291	193.04	
193.05	19305	HEALTH EDUCATION	793	0	793	193.05	
193.06	19306	RENTED SPACE	250,169	0	250,169	193.06	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description			PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.03	24.00	25.00	26.00	
193.07	19307	AUGUSTA PHARMACY		31,306	0	31,306	193.07
200.00		Cross Foot Adjustments	10,823	657,652	0	657,652	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,823	20,947,842	0	20,947,842	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIX (SQUARE FEET)	NEW BUILDING & FIX (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 & FIX	0	0	125,799			1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX	0	0	0	489,615		1.03
1.04	00104	CAP REL COSTS-14TH STREET	0	0	0	0	258,593	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BBC	0	0	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,545	4,830	549	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	0	27,815	89,179	60,628	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	3,821	18,537	61,148	61,362	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,779	750	376	8.00
9.00	00900	HOUSEKEEPING	0	0	4,147	498	2,631	9.00
10.00	01000	DIETARY	0	0	0	11,641	3,318	10.00
11.00	01100	CAFETERIA	0	0	0	5,220	4,266	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,070	433	3,768	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,137	7,157	1,219	16.00
20.00	02000	NURSING SCHOOL	0	14,320	0	21,278	7,627	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 PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED PRGM-RADIOLOGY	0	0	0	516	261	23.01
23.02	02302	PARAMED PRGM-LABORATORY	0	0	0	516	0	23.02
23.03	02303	PARAMED PRGM-PHARMACY	0	0	0	0	0	23.03
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	863	100,231	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	10,485	11,594	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	12,151	16,030	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,192	5,534	0	41.00
43.00	04300	NURSERY	0	0	0	3,567	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	9,504	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	11,424	25,945	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,797	2,081	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,473	0	54.00
60.00	06000	LABORATORY	0	0	692	10,761	336	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,907	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,425	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,642	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	556	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,526	4,521	41	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	4,332	4,751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,895	8,659	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	322	3,823	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
90.01	04950	OUTPATIENT INFUSION	0	0	0	1,165	0	90.01
91.00	09100	EMERGENCY	0	0	7,995	16,780	7,752	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	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	121,047	463,209	188,826	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,941	794	2,618	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	13,459	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	1,221	6,293	43,550	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	590	18,319	8,240	193.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIX (SQUARE FEET)	NEW BUILDING & FIX (SQUARE FEET)	14TH STREET (SQUARE FEET)		
		1.00	1.01	1.02	1.03	1.04		
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)	0	28,192	395,615	4,485,462	230,183	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1.554049	3.144818	9.161202	0.890136	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 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		MOB PHASE I (SQUARE FEET)	BBC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.05	1.06	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 & FIX					1.02
1.03	00103	CAP REL COSTS-NEW BUILDING & FIX					1.03
1.04	00104	CAP REL COSTS-14TH STREET					1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	3,997				1.05
1.06	00106	CAP REL COSTS-BBC	0	4,987			1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP			13,058,731		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	113,293	89,097,612	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,472	3,662	4,737,774	8,115,618	-58,341,119
6.00	00600	MAINTENANCE & REPAIRS	0	77	273,792	2,396,030	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	4,127	64,811	0
9.00	00900	HOUSEKEEPING	0	0	95,407	2,241,331	0
10.00	01000	DIETARY	0	0	112,386	625,107	0
11.00	01100	CAFETERIA	0	0	0	1,638,847	0
13.00	01300	NURSING ADMINISTRATION	0	497	839,321	5,237,342	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	751	213,069	470,263	0
20.00	02000	NURSING SCHOOL	0	0	18,336	4,071,421	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,102,679	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	393	0	0
23.00	02300	PARAMED PRGM	0	0	0	0	0
23.01	02301	PARAMED PRGM-RADIOLOGY	0	0	0	258,111	0
23.02	02302	PARAMED PRGM-LABORATORY	0	0	1,342	60,906	0
23.03	02303	PARAMED PRGM-PHARMACY	0	0	0	217,891	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	493,301	13,869,118	0
31.00	03100	INTENSIVE CARE UNIT	0	0	80,249	3,315,149	0
40.00	04000	SUBPROVIDER - IPF	0	0	15,841	3,980,008	0
41.00	04100	SUBPROVIDER - IRF	0	0	28,798	1,509,313	0
43.00	04300	NURSERY	0	0	16,050	448,621	0
44.00	04400	SKILLED NURSING FACILITY	0	0	280	1,450,456	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,525	0	1,923,951	7,496,266	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	40,561	1,226,156	0
53.00	05300	ANESTHESIOLOGY	0	0	167,821	167,186	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,341,281	5,168,541	0
60.00	06000	LABORATORY	0	0	229,331	3,014,875	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	357	134,846	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,110,051	0
66.00	06600	PHYSICAL THERAPY	0	0	6,921	1,337,368	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,087	552,827	0
68.00	06800	SPEECH PATHOLOGY	0	0	3,641	270,923	0
69.00	06900	ELECTROCARDIOLOGY	0	0	631,710	1,649,071	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	41,902	313,998	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	41,157	232,262	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	75,008	423,291	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	276,852	3,433,034	0
74.00	07400	RENAL DIALYSIS	0	0	7,654	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	476,332	0
90.00	09000	CLINIC	0	0	0	344,095	0
90.01	04950	OUTPATIENT INFUSION	0	0	0	53,728	0
91.00	09100	EMERGENCY	0	0	102,749	3,871,139	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	7,296	3,517,167	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	98,893	1,503,169	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,997	4,987	13,044,931	88,369,347	-58,341,119
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,231	197,886	0
192.01	19201	FASTCARE	0	0	12,282	332,965	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	DENMAN SERVICES	0	0	287	0	0
193.03	19303	MEALS ON WHEELS	0	0	0	0	0
193.04	19304	UNUSED SPACE	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	MOB PHASE I (SQUARE FEET)	BBC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
	1.05	1.06	2.00			
193.05 19305 HEALTH EDUCATION	0	0	0	16,318	0	193.05
193.06 19306 RENTED SPACE	0	0	0	0	0	193.06
193.07 19307 AUGUSTA PHARMACY	0	0	0	181,096	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)	20,706	269,779	12,974,130	23,575,140		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	5.180385	54.096451	0.993521	0.264599		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				183,088		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)				0.002055		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	6.00	8.00	9.00	10.00	
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
1.06	00106						1.06
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	173,325,504					6.00
8.00	00800		560,507				8.00
9.00	00900			1,252,274			9.00
10.00	01000				103,186		10.00
11.00	01100					185,904	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						23.00
23.01	02301						23.01
23.02	02302						23.02
23.03	02303						23.03
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,808,234	101,094	447,992	26,114	105,384	30.00
31.00	03100	4,690,281	22,079	79,329	7,504	15,109	31.00
40.00	04000	5,528,097	28,181	58,508	6,759	32,792	40.00
41.00	04100	2,137,924	10,726	45,284	2,623	16,049	41.00
43.00	04300	653,038	3,567	7,212	691	0	43.00
44.00	04400	2,034,863	9,504	36,924	2,447	16,570	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	16,425,213	38,894	161,126	12,421	0	50.00
52.00	05200	1,818,579	8,878	32,856	2,740	0	52.00
53.00	05300	693,283	1,306	0	0	0	53.00
54.00	05400	11,335,037	33,473	111,065	5,015	0	54.00
60.00	06000	7,216,002	11,789	259	1,849	0	60.00
62.00	06200	1,368,641	385	0	30	0	62.00
65.00	06500	2,976,949	1,907	629	2,058	0	65.00
66.00	06600	1,741,582	3,425	73	1,609	0	66.00
67.00	06700	724,473	1,642	0	0	0	67.00
68.00	06800	357,106	556	0	0	0	68.00
69.00	06900	3,507,860	13,088	36,686	784	0	69.00
70.00	07000	480,677	2,186	3,889	375	0	70.00
71.00	07100	8,294,434	9,083	6,145	692	0	71.00
72.00	07200	12,206,582	16,554	10,427	1,174	0	72.00
73.00	07300	15,467,163	4,472	0	911	0	73.00
74.00	07400	588,105	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,114,719	0	0	18	0	88.00
90.00	09000	547,666	0	0	0	0	90.00
90.01	04950	91,109	1,165	0	0	0	90.01
91.00	09100	6,022,301	32,527	192,924	9,192	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	6,080,492	4,925	0	3,683	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	2,674,420	0	3,132	648	0	116.00
118.00		171,210,596	459,582	1,247,844	99,551	185,904	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	18,853	6,353	4,430	0	0	190.00
192.00	19200	339,648	13,459	0	0	0	192.00
192.01	19201	552,547	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
193.02	19302	11,137	2,900	0	624	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	100,256	51,064	0	0	0	193.04
193.05	19305	20,685	0	0	0	0	193.05
193.06	19306	177,014	27,149	0	3,011	0	193.06
193.07	19307	894,768	0	0	0	0	193.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	6.00	8.00	9.00	10.00	
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)	58,341,119	10,596,894	1,616,376	4,422,615	1,678,183	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.336599	18.905908	1.290753	42.860611	9.027148	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	5,992,246	1,235,620	63,826	246,267	301,708	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.034572	2.204468	0.050968	2.386632	1.622924	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)		
	11.00	13.00	16.00	20.00	21.00		
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 & FIX					1.02	
1.03 00103	CAP REL COSTS-NEW BUILDING & FIX					1.03	
1.04 00104	CAP REL COSTS-14TH STREET					1.04	
1.05 00105	CAP REL COSTS-MOB PHASE I					1.05	
1.06 00106	CAP REL COSTS-BBC					1.06	
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	455,132				11.00	
13.00 01300	NURSING ADMINISTRATION	31,381	1,660,611			13.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	4,317	0	152,526		16.00	
20.00 02000	NURSING SCHOOL	24,420	0	0	28,026	20.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21,876	21.00	
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	6,508	0	0	0	22.00	
23.00 02300	PARAMED PRGM	0	0	0	0	23.00	
23.01 02301	PARAMED PRGM-RADIOLOGY	1,357	0	0	0	23.01	
23.02 02302	PARAMED PRGM-LABORATORY	341	0	0	0	23.02	
23.03 02303	PARAMED PRGM-PHARMACY	891	0	0	0	23.03	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	90,729	557,128	85,919	18,570	13,978	30.00
31.00 03100	INTENSIVE CARE UNIT	20,014	122,895	12,319	1,494	1,083	31.00
40.00 04000	SUBPROVIDER - I PF	28,631	175,808	26,736	1,690	433	40.00
41.00 04100	SUBPROVIDER - I RF	9,588	58,874	13,085	45	916	41.00
43.00 04300	NURSERY	2,320	14,245	281	310	400	43.00
44.00 04400	SKILLED NURSING FACILITY	10,066	61,810	13,510	2,500	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	47,889	294,063	0	878	1,100	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,112	43,672	0	905	0	52.00
53.00 05300	ANESTHESIOLOGY	1,258	7,724	0	0	117	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	30,868	0	0	0	267	54.00
60.00 06000	LABORATORY	23,814	0	0	0	133	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	980	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	12,852	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	5,996	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	2,797	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	1,305	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	9,276	0	0	105	983	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,391	0	0	0	1,033	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,630	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,794	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	15,556	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	2,022	0	0	244	0	90.00
90.01 04950	OUTPATIENT INFUSION	336	0	0	0	0	90.01
91.00 09100	EMERGENCY	23,445	143,963	676	1,205	1,433	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	18,889	115,990	0	45	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
116.00 11600	HOSPICE	9,349	57,410	0	35	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	454,122	1,653,582	152,526	28,026	21,876	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	908	0	0	0	0	192.00
192.01 19201	FASTCARE	0	7,029	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
		11.00	13.00	16.00	20.00	21.00	
193.05	19305 HEALTH EDUCATION	102	0	0	0	0	193.05
193.06	19306 RENTED SPACE	0	0	0	0	0	193.06
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)	4,594,440	11,352,426	2,179,816	5,857,042	1,863,816	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.094742	6.836295	14.291439	208.986013	85.199122	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	194,322	1,227,637	400,735	491,986	50,475	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.426957	0.739268	2.627323	17.554628	2.307323	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED PRGM-PHARMACY (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
	22.00	23.00	23.01	23.02	23.03	
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 & FIX						1.02
1.03 00103 CAP REL COSTS-NEW BUILDING & FIX						1.03
1.04 00104 CAP REL COSTS-14TH STREET						1.04
1.05 00105 CAP REL COSTS-MOB PHASE I						1.05
1.06 00106 CAP REL COSTS-BBC						1.06
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	21,876					22.00
23.00 02300 PARAMED PRGM		0				23.00
23.01 02301 PARAMED PRGM-RADIOLOGY			100			23.01
23.02 02302 PARAMED PRGM-LABORATORY				100		23.02
23.03 02303 PARAMED PRGM-PHARMACY					100	23.03
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	13,978	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	1,083	0	0	0	0	31.00
40.00 04000 SUBPROVIDER - IPF	433	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	916	0	0	0	0	41.00
43.00 04300 NURSERY	400	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,100	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	117	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	267	0	100	0	0	54.00
60.00 06000 LABORATORY	133	0	0	100	0	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	983	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1,033	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	0	0	100	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
90.01 04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	1,433	0	0	0	0	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	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	21,876	0	100	100	100	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	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	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED LABORATORY (ASSIGNED TIME)	PARAMED PHARMACY (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
	22.00	23.00	23.01	23.02	23.03	
193.05 19305 HEALTH EDUCATION	0	0	0	0	0	193.05
193.06 19306 RENTED SPACE	0	0	0	0	0	193.06
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)	2,889,710	0	405,510	101,785	395,419	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	132.094990	0.000000	4,055.100000	1,017.850000	3,954.190000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	76,214	0	18,394	9,760	10,823	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	3.483909	0.000000	183.940000	97.600000	108.230000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVII	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		42,205,643	24,832	42,230,475	30.00
31.00	03100 INTENSIVE CARE UNIT		8,777,323	0	8,777,323	31.00
40.00	04000 SUBPROVIDER - I/PF		10,809,048	4,499	10,813,547	40.00
41.00	04100 SUBPROVIDER - I/RF		4,071,757	13,874	4,085,631	41.00
43.00	04300 NURSERY		1,168,818	0	1,168,818	43.00
44.00	04400 SKILLED NURSING FACILITY		4,441,305	878	4,442,183	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		26,106,813	78,754	26,185,567	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,317,886	0	3,317,886	52.00
53.00	05300 ANESTHESIOLOGY		1,016,835	0	1,016,835	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		16,858,653	0	16,858,653	54.00
60.00	06000 LABORATORY		10,289,547	0	10,289,547	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1,847,782	0	1,847,782	62.00
65.00	06500 RESPIRATORY THERAPY	0	4,233,798	10,317	4,244,115	65.00
66.00	06600 PHYSICAL THERAPY	0	2,522,135	0	2,522,135	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,027,609	0	1,027,609	67.00
68.00	06800 SPEECH PATHOLOGY	0	500,994	0	500,994	68.00
69.00	06900 ELECTROCARDIOLOGY		5,132,582	10,767	5,143,349	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		729,030	5,316	734,346	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		11,322,195	0	11,322,195	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		16,740,444	0	16,740,444	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		21,349,441	0	21,349,441	73.00
74.00	07400 RENAL DIALYSIS		786,061	0	786,061	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		1,490,703	0	1,490,703	88.00
90.00	09000 CLINIC		803,415	0	803,415	90.00
90.01	04950 OUTPATIENT INFUSION		147,193	0	147,193	90.01
91.00	09100 EMERGENCY		10,789,679	214,413	11,004,092	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		8,043,493	0	8,043,493	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		9,371,174	0	9,371,174	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE		4,100,607		4,100,607	116.00
200.00	Subtotal (see instructions)		230,001,963	363,650	230,365,613	200.00
201.00	Less Observation Beds		8,043,493		8,043,493	201.00
202.00	Total (see instructions)		221,958,470	363,650	222,322,120	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet C Part I Date/Time Prepared: 2/26/2016 8:50 pm	
			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	61,378,905		61,378,905		30.00	
31.00	03100	INTENSIVE CARE UNIT	33,322,386		33,322,386		31.00	
40.00	04000	SUBPROVIDER - IPF	21,503,463		21,503,463		40.00	
41.00	04100	SUBPROVIDER - IRF	5,963,986		5,963,986		41.00	
43.00	04300	NURSERY	3,059,825		3,059,825		43.00	
44.00	04400	SKILLED NURSING FACILITY	4,767,986		4,767,986		44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,857,814	62,999,193	91,857,007	0.284211	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,445,056	660,349	6,105,405	0.543434	52.00	
53.00	05300	ANESTHESIOLOGY	8,288,710	12,167,164	20,455,874	0.049709	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,905,959	94,920,734	130,826,693	0.128862	54.00	
60.00	06000	LABORATORY	41,468,471	54,805,686	96,274,157	0.106878	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,154,666	1,546,839	4,701,505	0.393019	62.00	
65.00	06500	RESPIRATORY THERAPY	10,386,710	3,084,120	13,470,830	0.314294	65.00	
66.00	06600	PHYSICAL THERAPY	3,642,932	375,854	4,018,786	0.627586	66.00	
67.00	06700	OCCUPATIONAL THERAPY	2,334,778	74,084	2,408,862	0.426595	67.00	
68.00	06800	SPEECH PATHOLOGY	961,231	372,653	1,333,884	0.375590	68.00	
69.00	06900	ELECTROCARDIOLOGY	32,411,725	44,697,093	77,108,818	0.066563	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	253,415	2,375,404	2,628,819	0.277322	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,107,971	31,851,819	64,959,790	0.174295	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,099,939	18,377,574	47,477,513	0.352597	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	73,202,494	34,889,325	108,091,819	0.197512	73.00	
74.00	07400	RENAL DIALYSIS	1,777,884	0	1,777,884	0.442133	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	724,997	724,997		88.00	
90.00	09000	CLINIC	238	495,885	496,123	1.619387	90.00	
90.01	04950	OUTPATIENT INFUSION	10,098	478,092	488,190	0.301508	90.01	
91.00	09100	EMERGENCY	10,550,743	29,501,874	40,052,617	0.269388	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,113,152	19,652,792	22,765,944	0.353313	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	7,739,596	7,739,596		101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	49,177	3,987,053	4,036,230		116.00	
200.00		Subtotal (see instructions)	454,019,714	425,778,180	879,797,894		200.00	
201.00		Less Observation Beds					201.00	
202.00		Total (see instructions)	454,019,714	425,778,180	879,797,894		202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/26/2016 8:50 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		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	0.285069		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543434		52.00
53.00	05300 ANESTHESIOLOGY	0.049709		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128862		54.00
60.00	06000 LABORATORY	0.106878		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019		62.00
65.00	06500 RESPIRATORY THERAPY	0.315060		65.00
66.00	06600 PHYSICAL THERAPY	0.627586		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.426595		67.00
68.00	06800 SPEECH PATHOLOGY	0.375590		68.00
69.00	06900 ELECTROCARDIOLOGY	0.066702		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.279344		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.352597		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.197512		73.00
74.00	07400 RENAL DIALYSIS	0.442133		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	1.619387		90.00
90.01	04950 OUTPATIENT INFUSION	0.301508		90.01
91.00	09100 EMERGENCY	0.274741		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.353313		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 10/01/2014
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		42,205,643	24,832	42,230,475	30.00
31.00	03100	INTENSIVE CARE UNIT		8,777,323	0	8,777,323	31.00
40.00	04000	SUBPROVIDER - IPF		10,809,048	4,499	10,813,547	40.00
41.00	04100	SUBPROVIDER - IRF		4,071,757	13,874	4,085,631	41.00
43.00	04300	NURSERY		1,168,818	0	1,168,818	43.00
44.00	04400	SKILLED NURSING FACILITY		4,441,305	878	4,442,183	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		26,106,813	78,754	26,185,567	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		3,317,886	0	3,317,886	52.00
53.00	05300	ANESTHESIOLOGY		1,016,835	0	1,016,835	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		16,858,653	0	16,858,653	54.00
60.00	06000	LABORATORY		10,289,547	0	10,289,547	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		1,847,782	0	1,847,782	62.00
65.00	06500	RESPIRATORY THERAPY	0	4,233,798	10,317	4,244,115	65.00
66.00	06600	PHYSICAL THERAPY	0	2,522,135	0	2,522,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,027,609	0	1,027,609	67.00
68.00	06800	SPEECH PATHOLOGY	0	500,994	0	500,994	68.00
69.00	06900	ELECTROCARDIOLOGY		5,132,582	10,767	5,143,349	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		729,030	5,316	734,346	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		11,322,195	0	11,322,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		16,740,444	0	16,740,444	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		21,349,441	0	21,349,441	73.00
74.00	07400	RENAL DIALYSIS		786,061	0	786,061	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		1,490,703	0	1,490,703	88.00
90.00	09000	CLINIC		803,415	0	803,415	90.00
90.01	04950	OUTPATIENT INFUSION		147,193	0	147,193	90.01
91.00	09100	EMERGENCY		10,789,679	214,413	11,004,092	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		8,043,493	0	8,043,493	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		9,371,174	0	9,371,174	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE		4,100,607		4,100,607	116.00
200.00		Subtotal (see instructions)	0	230,001,963	363,650	230,365,613	200.00
201.00		Less Observation Beds		8,043,493		8,043,493	201.00
202.00		Total (see instructions)	0	221,958,470	363,650	222,322,120	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet C Part I Date/Time Prepared: 2/26/2016 8:50 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,378,905		61,378,905			30.00
31.00	03100	INTENSIVE CARE UNIT	33,322,386		33,322,386			31.00
40.00	04000	SUBPROVIDER - IPF	21,503,463		21,503,463			40.00
41.00	04100	SUBPROVIDER - IRF	5,963,986		5,963,986			41.00
43.00	04300	NURSERY	3,059,825		3,059,825			43.00
44.00	04400	SKILLED NURSING FACILITY	4,767,986		4,767,986			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,857,814	62,999,193	91,857,007	0.284211	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,445,056	660,349	6,105,405	0.543434	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,288,710	12,167,164	20,455,874	0.049709	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,905,959	94,920,734	130,826,693	0.128862	0.000000	54.00
60.00	06000	LABORATORY	41,468,471	54,805,686	96,274,157	0.106878	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,154,666	1,546,839	4,701,505	0.393019	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	10,386,710	3,084,120	13,470,830	0.314294	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,642,932	375,854	4,018,786	0.627586	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,334,778	74,084	2,408,862	0.426595	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	961,231	372,653	1,333,884	0.375590	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	32,411,725	44,697,093	77,108,818	0.066563	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	253,415	2,375,404	2,628,819	0.277322	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,107,971	31,851,819	64,959,790	0.174295	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,099,939	18,377,574	47,477,513	0.352597	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,202,494	34,889,325	108,091,819	0.197512	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,777,884	0	1,777,884	0.442133	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	724,997	724,997	2.056151	0.000000	88.00
90.00	09000	CLINIC	238	495,885	496,123	1.619387	0.000000	90.00
90.01	04950	OUTPATIENT INFUSION	10,098	478,092	488,190	0.301508	0.000000	90.01
91.00	09100	EMERGENCY	10,550,743	29,501,874	40,052,617	0.269388	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,113,152	19,652,792	22,765,944	0.353313	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	7,739,596	7,739,596			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	49,177	3,987,053	4,036,230			116.00
200.00		Subtotal (see instructions)	454,019,714	425,778,180	879,797,894			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	454,019,714	425,778,180	879,797,894			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/26/2016 8:50 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
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
90.01	04950	OUTPATIENT INFUSION	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
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 10/01/2014 To 09/30/2015	Worksheet D Part I Date/Time Prepared: 2/26/2016 8:50 pm
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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		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,406,288	0	3,406,288	42,753	79.67	30.00	
31.00	INTENSIVE CARE UNIT	647,680	0	647,680	5,015	129.15	31.00	
40.00	SUBPROVIDER - IPF	700,100	0	700,100	10,875	64.38	40.00	
41.00	SUBPROVIDER - IRF	315,240	0	315,240	5,339	59.04	41.00	
43.00	NURSERY	94,263		94,263	2,360	39.94	43.00	
44.00	SKILLED NURSING FACILITY	314,016		314,016	5,492	57.18	44.00	
200.00	Total (lines 30-199)	5,477,587		5,477,587	71,834		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	21,320	1,698,564					30.00
31.00	INTENSIVE CARE UNIT	2,732	352,838					31.00
40.00	SUBPROVIDER - IPF	1,907	122,773					40.00
41.00	SUBPROVIDER - IRF	3,559	210,123					41.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	4,305	246,160					44.00
200.00	Total (lines 30-199)	33,823	2,630,458					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part II Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIII	Hospital	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	4,140,227	91,857,007	0.045073	14,134,154	637,069	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	209,236	6,105,405	0.034271	29,627	1,015	52.00
53.00	05300 ANESTHESIOLOGY	224,023	20,455,874	0.010952	3,906,334	42,782	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,557,580	130,826,693	0.027193	19,999,454	543,845	54.00
60.00	06000 LABORATORY	776,297	96,274,157	0.008063	22,579,269	182,057	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	52,815	4,701,505	0.011234	1,892,110	21,256	62.00
65.00	06500 RESPIRATORY THERAPY	209,690	13,470,830	0.015566	7,547,608	117,486	65.00
66.00	06600 PHYSICAL THERAPY	115,165	4,018,786	0.028657	998,179	28,605	66.00
67.00	06700 OCCUPATIONAL THERAPY	50,116	2,408,862	0.020805	424,175	8,825	67.00
68.00	06800 SPEECH PATHOLOGY	23,397	1,333,884	0.017541	314,201	5,511	68.00
69.00	06900 ELECTROCARDIOLOGY	857,400	77,108,818	0.011119	18,816,962	209,226	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	109,689	2,628,819	0.041726	156,605	6,535	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	454,895	64,959,790	0.007003	16,040,148	112,329	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	728,194	47,477,513	0.015338	14,842,077	227,648	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	871,845	108,091,819	0.008066	39,578,220	319,238	73.00
74.00	07400 RENAL DIALYSIS	27,936	1,777,884	0.015713	514,833	8,090	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	72,734	724,997	0.100323	0	0	88.00
90.00	09000 CLINIC	86,502	496,123	0.174356	238	41	90.00
90.01	04950 OUTPATIENT INFUSION	16,644	488,190	0.034093	10,098	344	90.01
91.00	09100 EMERGENCY	728,158	40,052,617	0.018180	5,306,933	96,480	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	648,780	22,765,944	0.028498	1,996,167	56,887	92.00
200.00	Total (lines 50-199)	13,961,323	738,025,517		169,087,392	2,625,269	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part III Date/Time Prepared: 2/26/2016 8:50 pm
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Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			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)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,880,870	0	0	0	3,880,870	30.00
31.00	03100	INTENSIVE CARE UNIT	312,225	0	0	0	312,225	31.00
40.00	04000	SUBPROVIDER - IPF	353,186	0	0	0	353,186	40.00
41.00	04100	SUBPROVIDER - IRF	9,404	0	0	0	9,404	41.00
43.00	04300	NURSERY	64,786	0	0	0	64,786	43.00
44.00	04400	SKILLED NURSING FACILITY	522,465	0	0	0	522,465	44.00
200.00		Total (lines 30-199)	5,142,936	0	0	0	5,142,936	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)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,753	90.77	21,320	1,935,216	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,015	62.26	2,732	170,094	0	31.00
40.00	04000	SUBPROVIDER - IPF	10,875	32.48	1,907	61,939	0	40.00
41.00	04100	SUBPROVIDER - IRF	5,339	1.76	3,559	6,264	0	41.00
43.00	04300	NURSERY	2,360	27.45	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,492	95.13	4,305	409,535	0	44.00
200.00		Total (lines 30-199)	71,834		33,823	2,583,048	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
41.00	04100	SUBPROVIDER - IRF	0	0				41.00
43.00	04300	NURSERY	0	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
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Cost Center Description		Title XVIII				Hospital		
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS	
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	183,490	0	0	183,490	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	189,132	0	0	189,132	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	405,510	0	405,510	54.00
60.00	06000	LABORATORY	0	0	101,785	0	101,785	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	21,944	0	0	21,944	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	395,419	0	395,419	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	50,993	0	0	50,993	90.00
90.01	04950	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	251,828	0	0	251,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	739,173	0	0	739,173	92.00
200.00		Total (lines 50-199)	0	1,436,560	902,714	0	2,339,274	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet D
Part IV
Date/Time Prepared:
2/26/2016 8:50 pm

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		
					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	183,490	91,857,007	0.001998	0.001998	14,134,154	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	189,132	6,105,405	0.030978	0.030978	29,627	52.00
53.00	05300 ANESTHESIOLOGY	0	20,455,874	0.000000	0.000000	3,906,334	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	405,510	130,826,693	0.003100	0.003100	19,999,454	54.00
60.00	06000 LABORATORY	101,785	96,274,157	0.001057	0.001057	22,579,269	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,701,505	0.000000	0.000000	1,892,110	62.00
65.00	06500 RESPIRATORY THERAPY	0	13,470,830	0.000000	0.000000	7,547,608	65.00
66.00	06600 PHYSICAL THERAPY	0	4,018,786	0.000000	0.000000	998,179	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,408,862	0.000000	0.000000	424,175	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,333,884	0.000000	0.000000	314,201	68.00
69.00	06900 ELECTROCARDIOLOGY	21,944	77,108,818	0.000285	0.000285	18,816,962	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,628,819	0.000000	0.000000	156,605	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,959,790	0.000000	0.000000	16,040,148	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	47,477,513	0.000000	0.000000	14,842,077	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	395,419	108,091,819	0.003658	0.003658	39,578,220	73.00
74.00	07400 RENAL DIALYSIS	0	1,777,884	0.000000	0.000000	514,833	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	724,997	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	50,993	496,123	0.102783	0.102783	238	90.00
90.01	04950 OUTPATIENT INFUSION	0	488,190	0.000000	0.000000	10,098	90.01
91.00	09100 EMERGENCY	251,828	40,052,617	0.006287	0.006287	5,306,933	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	739,173	22,765,944	0.032468	0.032468	1,996,167	92.00
200.00	Total (lines 50-199)	2,339,274	738,025,517			169,087,392	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	28,240	21,534,081	43,025	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	918	8,445	262	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	4,079,232	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	61,998	31,319,155	97,089	0	0	54.00
60.00	06000 LABORATORY	23,866	8,088,370	8,549	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	713,791	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,524,859	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,803	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	993	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	5,363	20,295,997	5,784	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	693,288	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,794,115	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,385,243	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	144,777	10,114,210	36,998	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	24	137,984	14,182	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	292,818	0	0	0	90.01
91.00	09100 EMERGENCY	33,365	5,946,719	37,387	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	64,812	8,013,168	260,172	0	0	92.00
200.00	Total (lines 50-199)	363,363	132,944,271	503,448	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	Title XVIII	Hospital	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
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	0	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
90.01	04950 OUTPATIENT INFUSION	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/26/2016 8:50 pm
	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	0.284211	21,534,081	0	0	6,120,223	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.543434	8,445	0	0	4,589	52.00
53.00 05300 ANESTHESIOLOGY	0.049709	4,079,232	0	0	202,775	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.128862	31,319,155	4,865	0	4,035,849	54.00
60.00 06000 LABORATORY	0.106878	8,088,370	717	0	864,469	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019	713,791	0	0	280,533	62.00
65.00 06500 RESPIRATORY THERAPY	0.314294	1,524,859	0	0	479,254	65.00
66.00 06600 PHYSICAL THERAPY	0.627586	1,803	0	0	1,132	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.426595	993	0	0	424	67.00
68.00 06800 SPEECH PATHOLOGY	0.375590	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.066563	20,295,997	0	0	1,350,962	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.277322	693,288	0	0	192,264	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295	11,794,115	0	0	2,055,655	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.352597	8,385,243	0	0	2,956,612	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.197512	10,114,210	0	127,723	1,997,678	73.00
74.00 07400 RENAL DIALYSIS	0.442133	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000				0	88.00
90.00 09000 CLINIC	1.619387	137,984	0	0	223,449	90.00
90.01 04950 OUTPATIENT INFUSION	0.301508	292,818	0	0	88,287	90.01
91.00 09100 EMERGENCY	0.269388	5,946,719	0	0	1,601,975	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.353313	8,013,168	0	0	2,831,156	92.00
200.00	Subtotal (see instructions)	132,944,271	5,582	127,723	25,287,286	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	132,944,271	5,582	127,723	25,287,286	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/26/2016 8:50 pm
	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	627	0		54.00
60.00 06000 LABORATORY	77	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	25,227		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
90.01 04950 OUTPATIENT INFUSION	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	704	25,227		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	704	25,227		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140015 Component CCN: 14S015		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part II Date/Time Prepared: 2/26/2016 8:50 pm	
		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	4,140,227	91,857,007	0.045073	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,236	6,105,405	0.034271	0	0 52.00
53.00	05300	ANESTHESIOLOGY	224,023	20,455,874	0.010952	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,557,580	130,826,693	0.027193	69,560	1,892 54.00
60.00	06000	LABORATORY	776,297	96,274,157	0.008063	429,883	3,466 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	52,815	4,701,505	0.011234	123	1 62.00
65.00	06500	RESPIRATORY THERAPY	209,690	13,470,830	0.015566	25,703	400 65.00
66.00	06600	PHYSICAL THERAPY	115,165	4,018,786	0.028657	1,459	42 66.00
67.00	06700	OCCUPATIONAL THERAPY	50,116	2,408,862	0.020805	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	23,397	1,333,884	0.017541	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	857,400	77,108,818	0.011119	54,051	601 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	109,689	2,628,819	0.041726	820	34 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,895	64,959,790	0.007003	2,079	15 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	728,194	47,477,513	0.015338	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,845	108,091,819	0.008066	320,843	2,588 73.00
74.00	07400	RENAL DIALYSIS	27,936	1,777,884	0.015713	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	72,734	724,997	0.100323	0	0 88.00
90.00	09000	CLINIC	86,502	496,123	0.174356	0	0 90.00
90.01	04950	OUTPATIENT INFUSION	16,644	488,190	0.034093	0	0 90.01
91.00	09100	EMERGENCY	728,158	40,052,617	0.018180	192,247	3,495 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,765,944	0.000000	0	0 92.00
200.00		Total (Lines 50-199)	13,312,543	738,025,517		1,096,768	12,534 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	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	183,490	0	0	183,490	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	189,132	0	0	189,132	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	405,510	0	405,510	54.00
60.00	06000 LABORATORY	0	0	101,785	0	101,785	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	21,944	0	0	21,944	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	395,419	0	395,419	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	50,993	0	0	50,993	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	251,828	0	0	251,828	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	697,387	902,714	0	1,600,101	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	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	183,490	91,857,007	0.001998	0.001998	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	189,132	6,105,405	0.030978	0.030978	0	52.00
53.00	05300 ANESTHESIOLOGY	0	20,455,874	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	405,510	130,826,693	0.003100	0.003100	69,560	54.00
60.00	06000 LABORATORY	101,785	96,274,157	0.001057	0.001057	429,883	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,701,505	0.000000	0.000000	123	62.00
65.00	06500 RESPIRATORY THERAPY	0	13,470,830	0.000000	0.000000	25,703	65.00
66.00	06600 PHYSICAL THERAPY	0	4,018,786	0.000000	0.000000	1,459	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,408,862	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,333,884	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	21,944	77,108,818	0.000285	0.000285	54,051	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,628,819	0.000000	0.000000	820	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,959,790	0.000000	0.000000	2,079	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	47,477,513	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	395,419	108,091,819	0.003658	0.003658	320,843	73.00
74.00	07400 RENAL DIALYSIS	0	1,777,884	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	724,997	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	50,993	496,123	0.102783	0.102783	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	488,190	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	251,828	40,052,617	0.006287	0.006287	192,247	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	22,765,944	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	1,600,101	738,025,517			1,096,768	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
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	Title XVIII	Subprovider - IPF	PPS
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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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	216	0	0	0	0	54.00
60.00	06000 LABORATORY	454	0	0	0	0	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	15	0	0	0	0	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	1,174	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	0	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	1,209	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	3,068	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
Title XVII		Subprovider - IPF	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . AI Other Medical Education Cost	
	23.00	24.00	
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	0	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
90.01 04950 OUTPATIENT INFUSION	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs PPS Services (see inst.)		
		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.)
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.284211	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.543434	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.049709	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128862	0	0	0	0	54.00
60.00	06000	LABORATORY	0.106878	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.314294	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.627586	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.426595	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.375590	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066563	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277322	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.352597	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197512	0	0	2,803	0	73.00
74.00	07400	RENAL DIALYSIS	0.442133	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.619387	0	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	0.301508	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.269388	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.353313	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	2,803	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	2,803	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015	Period:	Worksheet D
	Component CCN: 14S015	From 10/01/2014 To 09/30/2015	Part V Date/Time Prepared: 2/26/2016 8:50 pm
	Title XVII I	Subprovider - IPF	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	0	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	554	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
90.01 04950 OUTPATIENT INFUSION	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	554	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	554	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140015 Component CCN: 14T015		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part II Date/Time Prepared: 2/26/2016 8:50 pm		
				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	4,140,227	91,857,007	0.045073	13,643	615	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	209,236	6,105,405	0.034271	0	0	52.00
53.00	05300	ANESTHESIOLOGY	224,023	20,455,874	0.010952	2,366	26	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,557,580	130,826,693	0.027193	361,197	9,822	54.00
60.00	06000	LABORATORY	776,297	96,274,157	0.008063	728,703	5,876	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	52,815	4,701,505	0.011234	19,588	220	62.00
65.00	06500	RESPIRATORY THERAPY	209,690	13,470,830	0.015566	142,764	2,222	65.00
66.00	06600	PHYSICAL THERAPY	115,165	4,018,786	0.028657	974,932	27,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	50,116	2,408,862	0.020805	749,152	15,586	67.00
68.00	06800	SPEECH PATHOLOGY	23,397	1,333,884	0.017541	310,622	5,449	68.00
69.00	06900	ELECTROCARDIOLOGY	857,400	77,108,818	0.011119	41,596	463	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	109,689	2,628,819	0.041726	4,098	171	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,895	64,959,790	0.007003	54,080	379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	728,194	47,477,513	0.015338	22,218	341	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	871,845	108,091,819	0.008066	1,195,337	9,642	73.00
74.00	07400	RENAL DIALYSIS	27,936	1,777,884	0.015713	54,913	863	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	72,734	724,997	0.100323	0	0	88.00
90.00	09000	CLINIC	86,502	496,123	0.174356	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	16,644	488,190	0.034093	0	0	90.01
91.00	09100	EMERGENCY	728,158	40,052,617	0.018180	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,765,944	0.000000	0	0	92.00
200.00		Total (lines 50-199)	13,312,543	738,025,517		4,675,209	79,614	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	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	183,490	0	0	183,490	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	189,132	0	0	189,132	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	405,510	0	405,510	54.00
60.00	06000 LABORATORY	0	0	101,785	0	101,785	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	21,944	0	0	21,944	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	395,419	0	395,419	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	50,993	0	0	50,993	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	251,828	0	0	251,828	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	697,387	902,714	0	1,600,101	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	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	183,490	91,857,007	0.001998	0.001998	13,643	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	189,132	6,105,405	0.030978	0.030978	0	52.00
53.00	05300 ANESTHESIOLOGY	0	20,455,874	0.000000	0.000000	2,366	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	405,510	130,826,693	0.003100	0.003100	361,197	54.00
60.00	06000 LABORATORY	101,785	96,274,157	0.001057	0.001057	728,703	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,701,505	0.000000	0.000000	19,588	62.00
65.00	06500 RESPIRATORY THERAPY	0	13,470,830	0.000000	0.000000	142,764	65.00
66.00	06600 PHYSICAL THERAPY	0	4,018,786	0.000000	0.000000	974,932	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,408,862	0.000000	0.000000	749,152	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,333,884	0.000000	0.000000	310,622	68.00
69.00	06900 ELECTROCARDIOLOGY	21,944	77,108,818	0.000285	0.000285	41,596	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,628,819	0.000000	0.000000	4,098	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,959,790	0.000000	0.000000	54,080	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	47,477,513	0.000000	0.000000	22,218	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	395,419	108,091,819	0.003658	0.003658	1,195,337	73.00
74.00	07400 RENAL DIALYSIS	0	1,777,884	0.000000	0.000000	54,913	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	724,997	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	50,993	496,123	0.102783	0.102783	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	488,190	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	251,828	40,052,617	0.006287	0.006287	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	22,765,944	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	1,600,101	738,025,517			4,675,209	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	27	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,120	0	0	0	0	54.00
60.00	06000 LABORATORY	770	0	0	0	0	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	12	0	0	0	0	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	4,373	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	0	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	6,302	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . AI Other Medical Education Cost	
	23.00	24.00	
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	0	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
90.01 04950 OUTPATIENT INFUSION	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/26/2016 8:50 pm
	Title XVIII	Subprovider - IRF	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	0.284211	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.543434	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.049709	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.128862	0	0	0	0	54.00
60.00 06000 LABORATORY	0.106878	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0.314294	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.627586	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.426595	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.375590	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.066563	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.277322	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.352597	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.197512	0	0	1,381	0	73.00
74.00 07400 RENAL DIALYSIS	0.442133	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00
90.00 09000 CLINIC	1.619387	0	0	0	0	90.00
90.01 04950 OUTPATIENT INFUSION	0.301508	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.269388	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.353313	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	1,381	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	1,381	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015	Period:	Worksheet D
	Component CCN: 14T015	From 10/01/2014 To 09/30/2015	Part V Date/Time Prepared: 2/26/2016 8:50 pm
	Title XVII I	Subprovider - IRF	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	0	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	273	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
90.01 04950 OUTPATIENT INFUSION	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	273	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	273	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	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	183,490	0	0	183,490	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	189,132	0	0	189,132	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	405,510	0	405,510	54.00
60.00	06000 LABORATORY	0	0	101,785	0	101,785	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	21,944	0	0	21,944	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	395,419	0	395,419	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	50,993	0	0	50,993	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	251,828	0	0	251,828	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	697,387	902,714	0	1,600,101	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	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	183,490	91,857,007	0.001998	0.001998	7,508	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	189,132	6,105,405	0.030978	0.030978	0	52.00
53.00	05300 ANESTHESIOLOGY	0	20,455,874	0.000000	0.000000	776	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	405,510	130,826,693	0.003100	0.003100	195,764	54.00
60.00	06000 LABORATORY	101,785	96,274,157	0.001057	0.001057	947,328	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,701,505	0.000000	0.000000	37,407	62.00
65.00	06500 RESPIRATORY THERAPY	0	13,470,830	0.000000	0.000000	554,693	65.00
66.00	06600 PHYSICAL THERAPY	0	4,018,786	0.000000	0.000000	602,046	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,408,862	0.000000	0.000000	443,780	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,333,884	0.000000	0.000000	54,858	68.00
69.00	06900 ELECTROCARDIOLOGY	21,944	77,108,818	0.000285	0.000285	64,938	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,628,819	0.000000	0.000000	1,949	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,959,790	0.000000	0.000000	168,338	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	47,477,513	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	395,419	108,091,819	0.003658	0.003658	2,300,511	73.00
74.00	07400 RENAL DIALYSIS	0	1,777,884	0.000000	0.000000	61,998	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	724,997	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	50,993	496,123	0.102783	0.102783	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	488,190	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	251,828	40,052,617	0.006287	0.006287	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	22,765,944	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	1,600,101	738,025,517			5,441,894	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	15	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	607	0	0	0	0	54.00
60.00	06000 LABORATORY	1,001	0	0	0	0	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	19	0	0	0	0	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	8,415	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	0	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	10,057	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 8:50 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
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	0	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
90.01	04950 OUTPATIENT INFUSION	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)		
		Cost Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.284211	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.543434	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.049709	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.128862	0	0	0	0	54.00
60.00	06000	LABORATORY	0.106878	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.314294	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.627586	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.426595	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.375590	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066563	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.277322	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.352597	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.197512	0	0	10,279	0	73.00
74.00	07400	RENAL DIALYSIS	0.442133	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.619387	0	0	0	0	90.00
90.01	04950	OUTPATIENT INFUSION	0.301508	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.269388	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.353313	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	10,279	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	10,279	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/26/2016 8:50 pm
	Title XVIII	Skilled Nursing Facility	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	0	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	2,030	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
90.01 04950 OUTPATIENT INFUSION	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	2,030	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	2,030	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/26/2016 8:50 pm
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)		42,753	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		42,753	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)		34,610	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)		21,320	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)		42,230,475	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)		42,230,475	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)		42,230,475	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)		987.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		21,059,470	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)		21,059,470	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 2/26/2016 8:50 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	8,777,323	5,015	1,750.21	2,732	4,781,574		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							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					32,816,273		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					58,657,317		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)					4,156,712		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,988,632		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					7,145,344		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					51,511,973		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					8,143		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					987.78		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					8,043,493		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/26/2016 8:50 pm	
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	3,406,288	42,230,475	0.080659	8,043,493	648,780	90.00
91.00	Nursing School cost	3,880,870	42,230,475	0.091897	8,043,493	739,173	91.00
92.00	Allied health cost	0	42,230,475	0.000000	8,043,493	0	92.00
93.00	All other Medical Education	0	42,230,475	0.000000	8,043,493	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 8:50 pm
		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)		10,875	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,875	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)		10,875	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)		1,907	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)		10,813,547	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)		10,813,547	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)		10,813,547	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)		994.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,896,225	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,896,225	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
		Component CCN: 14S015				Date/Time Prepared: 2/26/2016 8:50 pm	
		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)					184,355		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,080,580		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)					184,712		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					15,602		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					200,314		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,880,266		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					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 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/26/2016 8:50 pm	
		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	700,100	10,813,547	0.064743	0	0	90.00
91.00	Nursing School cost	353,186	10,813,547	0.032661	0	0	91.00
92.00	Allied health cost	0	10,813,547	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,813,547	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 8:50 pm
		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)		5,339	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,339	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)		5,339	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)		3,559	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)		4,085,631	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)		4,085,631	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,085,631	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)		765.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,723,489	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)		2,723,489	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
		Component CCN: 14T015				Date/Time Prepared: 2/26/2016 8:50 pm	
		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)					1,510,768		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,234,257		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)					216,387		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					85,916		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					302,303		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,931,954		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					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 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/26/2016 8:50 pm	
		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	315,240	4,085,631	0.077158	0	0	90.00
91.00	Nursing School cost	9,404	4,085,631	0.002302	0	0	91.00
92.00	Allied health cost	0	4,085,631	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,085,631	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 8:50 pm
		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)		5,492	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,492	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)		5,492	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)		4,305	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)		4,442,183	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)		4,442,183	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,442,183	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: From 10/01/2014 To 09/30/2015	Worksheet D-1	
		Component CCN: 145643		Date/Time Prepared: 2/26/2016 8:50 pm	
		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/IID ONLY				
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				4,442,183 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				808.85 71.00
72.00	Program routine service cost (line 9 x line 71)				3,482,099 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)				3,482,099 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)				3,482,099 83.00
84.00	Program inpatient ancillary services (see instructions)				1,421,435 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)				4,903,534 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 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/26/2016 8:50 pm	
		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 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 2/26/2016 8:50 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		40,497,226		30.00
31.00	03100 INTENSIVE CARE UNIT		18,513,622		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	0.285069	14,134,154	4,029,209	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543434	29,627	16,100	52.00
53.00	05300 ANESTHESIOLOGY	0.049709	3,906,334	194,180	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128862	19,999,454	2,577,170	54.00
60.00	06000 LABORATORY	0.106878	22,579,269	2,413,227	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019	1,892,110	743,635	62.00
65.00	06500 RESPIRATORY THERAPY	0.315060	7,547,608	2,377,949	65.00
66.00	06600 PHYSICAL THERAPY	0.627586	998,179	626,443	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.426595	424,175	180,951	67.00
68.00	06800 SPEECH PATHOLOGY	0.375590	314,201	118,011	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066702	18,816,962	1,255,129	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.279344	156,605	43,747	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295	16,040,148	2,795,718	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.352597	14,842,077	5,233,272	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.197512	39,578,220	7,817,173	73.00
74.00	07400 RENAL DIALYSIS	0.442133	514,833	227,625	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.619387	238	385	90.00
90.01	04950 OUTPATIENT INFUSION	0.301508	10,098	3,045	90.01
91.00	09100 EMERGENCY	0.274741	5,306,933	1,458,032	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.353313	1,996,167	705,272	92.00
200.00	Total (sum of lines 50-94 and 96-98)		169,087,392	32,816,273	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)		169,087,392		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 2/26/2016 8:50 pm
		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		3,741,715	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	0.285069	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543434	0	52.00
53.00	05300 ANESTHESIOLOGY	0.049709	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128862	69,560	54.00
60.00	06000 LABORATORY	0.106878	429,883	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019	123	62.00
65.00	06500 RESPIRATORY THERAPY	0.315060	25,703	65.00
66.00	06600 PHYSICAL THERAPY	0.627586	1,459	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.426595	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.375590	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066702	54,051	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.279344	820	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295	2,079	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.352597	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.197512	320,843	73.00
74.00	07400 RENAL DIALYSIS	0.442133	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000 CLINIC	1.619387	0	90.00
90.01	04950 OUTPATIENT INFUSION	0.301508	0	90.01
91.00	09100 EMERGENCY	0.274741	192,247	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.353313	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,096,768	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)		1,096,768	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 14T015	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 2/26/2016 8:50 pm	
		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		4,011,545		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.285069	13,643	3,889	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543434	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.049709	2,366	118	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128862	361,197	46,545	54.00
60.00	06000 LABORATORY	0.106878	728,703	77,882	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019	19,588	7,698	62.00
65.00	06500 RESPIRATORY THERAPY	0.315060	142,764	44,979	65.00
66.00	06600 PHYSICAL THERAPY	0.627586	974,932	611,854	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.426595	749,152	319,584	67.00
68.00	06800 SPEECH PATHOLOGY	0.375590	310,622	116,667	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066702	41,596	2,775	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.279344	4,098	1,145	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295	54,080	9,426	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.352597	22,218	7,834	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.197512	1,195,337	236,093	73.00
74.00	07400 RENAL DIALYSIS	0.442133	54,913	24,279	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.619387	0	0	90.00
90.01	04950 OUTPATIENT INFUSION	0.301508	0	0	90.01
91.00	09100 EMERGENCY	0.274741	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.353313	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,675,209	1,510,768	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)		4,675,209		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 2/26/2016 8:50 pm
		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	0.284211	7,508	2,134 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.543434	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.049709	776	39 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128862	195,764	25,227 54.00
60.00	06000 LABORATORY	0.106878	947,328	101,249 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.393019	37,407	14,702 62.00
65.00	06500 RESPIRATORY THERAPY	0.314294	554,693	174,337 65.00
66.00	06600 PHYSICAL THERAPY	0.627586	602,046	377,836 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.426595	443,780	189,314 67.00
68.00	06800 SPEECH PATHOLOGY	0.375590	54,858	20,604 68.00
69.00	06900 ELECTROCARDIOLOGY	0.066563	64,938	4,322 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.277322	1,949	541 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.174295	168,338	29,340 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.352597	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.197512	2,300,511	454,379 73.00
74.00	07400 RENAL DIALYSIS	0.442133	61,998	27,411 74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000 CLINIC	1.619387	0	0 90.00
90.01	04950 OUTPATIENT INFUSION	0.301508	0	0 90.01
91.00	09100 EMERGENCY	0.269388	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.353313	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,441,894	1,421,435 200.00
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)		5,441,894	1,421,435 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 8:50 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		41,823,289		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		1,001,532		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		227,363		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		180.35		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), 64 FR 26340 (May 12, 1998), and 67 FR 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		17.42		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)		17.42		12.00
13.00	Total allowable FTE count for the prior year.		16.92		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.		16.06		14.00
15.00	Sum of lines 12 through 14 divided by 3.		16.80		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		16.80		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.093152		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.100130		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.093152		21.00
22.00	IME payment adjustment (see instructions)		2,073,850		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		11,274		22.01
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)		-2.08		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
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		2,073,850		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 8:50 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	2.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		11,274		29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.42		30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.74		31.00
32.00	Sum of lines 30 and 31		19.16		32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.20		33.00
34.00	Disproportionate share adjustment (see instructions)		543,703		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	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000191834	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		0	1,467,078	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	1,467,078	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,467,078		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
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)		46,909,452		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		51,282,277		48.00
49.00	Total payment for inpatient operating costs (see instructions)		51,293,551		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,568,053		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		639,458		52.00
53.00	Nursing and Allied Health Managed Care payment		2,000		53.00
54.00	Special add-on payments for new technologies		1,107		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. 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, Pt. III, column 9, lines 30 through 35).		2,105,310		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		363,363		58.00
59.00	Total (sum of amounts on lines 49 through 58)		57,972,842		59.00
60.00	Primary payer payments		16,388		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		57,956,454		61.00
62.00	Deductibles billed to program beneficiaries		4,765,112		62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 8:50 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		72,632		63.00
64.00	Allowable bad debts (see instructions)		1,069,074		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		694,898		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,069,074		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		53,813,608		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (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
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-24,045		70.93
70.94	HRR adjustment amount (see instructions)		-363,874		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
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		53,425,689		71.00
71.01	Sequestration adjustment (see instructions)		1,068,514		71.01
72.00	Interim payments		51,725,001		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)		632,174		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,708,000		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. 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 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
	HSP Bonus Payment Amount	1.00	1.01	2.00
100.00	HSP bonus amount (see instructions)			0
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)			0
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)			0.0000
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 2/26/2016 8:50 pm	
		PPS					
	Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value		
	1.00	2.00	3.00	4.00	5.00		
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.42	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	14.74	0.00			14.74	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	19.16	0.00			14.74	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	180.35	0.00			180.35	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	5.20	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	2.19	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	5,138	0			5,138	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	673	0			673	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	492	0			492	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	6,303	0			6,303	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	41,985	0			41,985	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	783	0			783	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	42,768	0			42,768	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	14.74	0.00			14.74	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140015		Period: From 10/01/2014 To 09/30/2015		Worksheet DSH Date/Time Prepared: 2/26/2016 8:50 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	5.20		0.00	True	29.00
30.00	Line 28 or 29 as applicable		5.20		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet DSH Date/Time Prepared: 2/26/2016 8:50 pm
		Title VIII	Hospital	PPS
		Revised Percentage 6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	2.67		29.00
30.00	Line 28 or 29 as applicable	2.67		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		25,931	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		24,783,838	2.00
3.00	PPS payments		24,597,334	3.00
4.00	Outlier payment (see instructions)		90,789	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		22,231,103	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		503,448	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		25,931	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		133,305	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		133,305	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)		133,305	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		107,374	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)		25,931	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)		25,191,571	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		765	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		5,095,434	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		20,121,303	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		231,545	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		20,352,848	30.00
31.00	Primary payer payments		2,398	31.00
32.00	Subtotal (line 30 minus line 31)		20,350,450	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		910,557	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		591,862	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		20,942,312	37.00
38.00	MSP-LCC reconciliation amount from PS&R		458	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		20,941,854	40.00
40.01	Sequestration adjustment (see instructions)		418,837	40.01
41.00	Interim payments		20,313,363	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		209,654	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/26/2016 8:50 pm
		Component CCN: 14S015	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		554	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		554	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,803	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		2,803	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)		2,803	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,249	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)		554	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		554	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		554	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		554	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		554	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		554	40.00
40.01	Sequestration adjustment (see instructions)		11	40.01
41.00	Interim payments		834	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-291	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
		Overrides		
		1.00		
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/26/2016 8:50 pm
		Component CCN: 14T015	Title XVII I	Subprovider - IRF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		273	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		273	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,381	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,381	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)		1,381	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,108	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)		273	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		273	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		273	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		273	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		273	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		273	40.00
40.01	Sequestration adjustment (see instructions)		5	40.01
41.00	Interim payments		375	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-107	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
		Overrides		
		1.00		
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015 Component CCN: 145643	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,030	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,030	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		10,279	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		10,279	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)		10,279	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,249	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)		2,030	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,030	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,030	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,030	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,030	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,030	40.00
40.01	Sequestration adjustment (see instructions)		41	40.01
41.00	Interim payments		10,073	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-8,084	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

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		52,548,297		20,301,352	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	05/21/2015	13,348	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	05/21/2015	453,901	09/22/2015	1,337	3.50
3.51		09/22/2015	369,395		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)		-823,296		12,011	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)		51,725,001		20,313,363	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		632,174		209,654	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		52,357,175		20,523,017	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 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

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		1,402,008		834	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)		1,402,008		834	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		169,678		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		291	6.02
7.00	Total Medicare program liability (see instructions)		1,571,686		543	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 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

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					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		5,215,509		375	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)		5,215,509		375	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		67,725		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		107	6.02
7.00	Total Medicare program liability (see instructions)		5,283,234		268	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: 145643

Period:
From 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		1,496,072		10,073	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)		1,496,072		10,073	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		411,882		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		8,084	6.02
7.00	Total Medicare program liability (see instructions)		1,907,954		1,989	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 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		10,323	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		24,052	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		2,854	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		39,625	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		879,797,894	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		170,249,735	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		32,285	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		32,285	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32,285	32.00
		Overrides		
		1.00		
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140015 Component CCN: 14S015	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part II Date/Time Prepared: 2/26/2016 8:50 pm
		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)			1,653,844 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 42 CFR §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 instructions)			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 instructions)			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)			29.794521 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)			1,653,844 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)			1,653,844 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,653,844 18.00
19.00	Deductibles			219,428 19.00
20.00	Subtotal (line 18 minus line 19)			1,434,416 20.00
21.00	Coinsurance			3,780 21.00
22.00	Subtotal (line 20 minus line 21)			1,430,636 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			166,336 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			108,118 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)			1,538,754 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			65,007 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,603,761 31.00
31.01	Sequestration adjustment (see instructions)			32,075 31.01
32.00	Interim payments			1,402,008 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)			169,678 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 10/01/2014 To 09/30/2015	Worksheet E-3 Part III Date/Time Prepared: 2/26/2016 8:50 pm
		Title VIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			5,037,203 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0219 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			186,377 3.00
4.00	Outlier Payments			194,200 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 42 CFR §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 instructions)			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 instructions)			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)			14.627397 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)			5,417,780 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)			5,417,780 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			5,417,780 19.00
20.00	Deductibles			19,808 20.00
21.00	Subtotal (line 19 minus line 20)			5,397,972 21.00
22.00	Coinsurance			20,273 22.00
23.00	Subtotal (line 21 minus line 22)			5,377,699 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,216 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			790 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			5,378,489 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			12,566 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			5,391,055 32.00
32.01	Sequestration adjustment (see instructions)			107,821 32.01
33.00	Interim payments			5,215,509 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)			67,725 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 Wkst. E-3, Pt. III, line 4			194,200 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 10/01/2014 To 09/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2016 8:50 pm
		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)		1,588,320	1.00
2.00	Routine service other pass through costs		409,535	2.00
3.00	Ancillary service other pass through costs		10,057	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,007,912	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		61,716	7.00
8.00	Allowable bad debts (see instructions)		1,070	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		696	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,946,892	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		1,946,892	15.00
15.01	Sequestration adjustment (see instructions)		38,938	15.01
16.00	Interim payments		1,496,072	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		411,882	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 10/01/2014 To 09/30/2015	Worksheet E-4 Date/Time Prepared: 2/26/2016 8:50 pm	
		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)			18.23	6.00
7.00	Enter the lesser of line 5 or line 6			18.23	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.	18.23	0.00	18.23	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.	18.23	0.00	18.23	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	18.23	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	18.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	18.09	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	18.11	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	18.11	0.00		17.00
18.00	Per resident amount	82,990.14	0.00		18.00
19.00	Approved amount for resident costs	1,502,951	0	1,502,951	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)			1,502,951	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	29,518	3,310		26.00
27.00	Total Inpatient Days (see instructions)	55,839	55,839		27.00
28.00	Ratio of inpatient days to total inpatient days	0.528627	0.059278		28.00
29.00	Program direct GME amount	794,500	89,092		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		12,589		30.00
31.00	Net Program direct GME amount			871,003	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet E-4 Date/Time Prepared: 2/26/2016 8:50 pm
		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)		1,777,884	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)		70,462,165	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)		16,388	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		70,445,777	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		25,512,969	42.00
43.00	Primary payer payments (see instructions)		4,871	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		25,508,098	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		95,953,875	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.734163	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.265837	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		871,003	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		639,458	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		231,545	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 10/01/2014
To 09/30/2015

Worksheet G

Date/Time Prepared:
2/26/2016 8:50 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	91,387,669	0	0	0	1.00
2.00	Temporary investments	85,264,161	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	149,543,276	0	0	0	4.00
5.00	Other receivable	7,453,133	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-102,336,546	0	0	0	6.00
7.00	Inventory	6,872,834	0	0	0	7.00
8.00	Prepaid expenses	5,035,769	0	0	0	8.00
9.00	Other current assets	164,436	0	0	0	9.00
10.00	Due from other funds	3,386,959	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	246,771,691	0	0	0	11.00
FIXED ASSETS						
12.00	Land	13,183,024	0	0	0	12.00
13.00	Land improvements	7,763,985	0	0	0	13.00
14.00	Accumulated depreciation	-5,051,836	0	0	0	14.00
15.00	Buildings	209,595,267	0	0	0	15.00
16.00	Accumulated depreciation	-65,087,944	0	0	0	16.00
17.00	Leasehold improvements	10,143,933	0	0	0	17.00
18.00	Accumulated depreciation	-33,652,347	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	182,404,370	0	0	0	23.00
24.00	Accumulated depreciation	-133,372,042	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)	185,926,410	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	16,108,358	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	9,811,952	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	25,920,310	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	458,618,411	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	17,380,457	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,393,446	0	0	0	38.00
39.00	Payroll taxes payable	561,214	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,985,980	0	0	0	40.00
41.00	Deferred income	1,166,345	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	12,784,988	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	54,272,430	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	92,062,678	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	98,991,159	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	191,053,837	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	245,326,267	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	213,292,144				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)	213,292,144	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	458,618,411	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet G-1

Date/Time Prepared:
2/26/2016 8:50 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		220,886,659		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		15,161,938			2.00
3.00	Total (sum of line 1 and line 2)		236,048,597		0	3.00
4.00	CONTRIBUTIONS	4,211,068		0		4.00
5.00	NET REAL AND UNREAL GAINS/LOSSES	20,306		0		5.00
6.00	OTHER	477		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)		4,231,851		0	10.00
11.00	Subtotal (line 3 plus line 10)		240,280,448		0	11.00
12.00	PENSION LIABILITY ADJUSTMENT	22,536,427		0		12.00
13.00	NET ASSETS RELEASED	4,451,877		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)		26,988,304		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		213,292,144		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	NET REAL AND UNREAL GAINS/LOSSES		0			5.00
6.00	OTHER		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 10/01/2014
To 09/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	65,735,013		65,735,013	1.00
2.00	SUBPROVIDER - IPF	21,723,124		21,723,124	2.00
3.00	SUBPROVIDER - IRF	6,011,295		6,011,295	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	4,824,265		4,824,265	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)	98,293,697		98,293,697	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	33,359,648		33,359,648	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)	33,359,648		33,359,648	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	131,653,345		131,653,345	17.00
18.00	Ancillary services	349,454,591	476,181,745	825,636,336	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	724,997	724,997	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		7,739,596	7,739,596	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	49,177	3,987,053	4,036,230	26.00
27.00	NURSERY	3,248,670	0	3,248,670	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	484,405,783	488,633,391	973,039,174	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		316,603,732		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		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)		316,603,732		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140015

Period:
From 10/01/2014
To 09/30/2015

Worksheet G-3

Date/Time Prepared:
2/26/2016 8:50 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	973,039,174	1.00
2.00	Less contractual allowances and discounts on patients' accounts	656,723,363	2.00
3.00	Net patient revenues (line 1 minus line 2)	316,315,811	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	316,603,732	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-287,921	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-3,686,489	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	634,906	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	1,583,868	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	101,469	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	3,257,810	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	963,179	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	10,326,106	24.00
24.01	TRANSFERS	1,895,311	24.01
24.02	TRANSFERS	373,692	24.02
24.03	ROUNDING	7	24.03
25.00	Total other income (sum of lines 6-24)	15,449,859	25.00
26.00	Total (line 5 plus line 25)	15,161,938	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)	15,161,938	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140015

Period: From 10/01/2014

Worksheet H

HHA CCN: 147031

To 09/30/2015

Date/Time Prepared: 2/26/2016 8:50 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 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	450,293	0	0	0	450,293	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,304,527	0	158,622	0	659,116	6.00
7.00	Physical Therapy	869,650	0	76,934	0	319,681	7.00
8.00	Occupational Therapy	251,060	0	24,249	0	100,762	8.00
9.00	Speech Pathology	35,324	0	3,349	0	13,915	9.00
10.00	Medical Social Services	107,260	0	718	0	2,982	10.00
11.00	Home Health Aide	185,234	0	35,133	0	145,987	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	313,819	0	111,265	0	425,084	23.00
24.00	Total (sum of lines 1-23)	3,517,167	0	410,270	0	1,242,443	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	450,293	0	450,293		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	-2,205	2,120,060	-29,455	2,090,605		6.00
7.00	Physical Therapy	0	1,266,265	0	1,266,265		7.00
8.00	Occupational Therapy	0	376,071	0	376,071		8.00
9.00	Speech Pathology	0	52,588	0	52,588		9.00
10.00	Medical Social Services	0	110,960	0	110,960		10.00
11.00	Home Health Aide	0	366,354	0	366,354		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	425,084	0	425,084		23.00
24.00	Total (sum of lines 1-23)	-2,205	5,167,675	-29,455	5,138,220		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 10/01/2014 To 09/30/2015	Worksheet H-1 Part I Date/Time Prepared: 2/26/2016 8:50 pm
		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	450,293	0	0	0	450,293	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	2,090,605	0	0	0	2,090,605	6.00
7.00	Physical Therapy	1,266,265	0	0	0	1,266,265	7.00
8.00	Occupational Therapy	376,071	0	0	0	376,071	8.00
9.00	Speech Pathology	52,588	0	0	0	52,588	9.00
10.00	Medical Social Services	110,960	0	0	0	110,960	10.00
11.00	Home Health Aide	366,354	0	0	0	366,354	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	425,084	0	0	0	425,084	23.00
24.00	Total (sum of lines 1-23)	5,138,220	0	0	0	5,138,220	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	450,293					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	200,810	2,291,415				6.00
7.00	Physical Therapy	121,630	1,387,895				7.00
8.00	Occupational Therapy	36,123	412,194				8.00
9.00	Speech Pathology	5,051	57,639				9.00
10.00	Medical Social Services	10,658	121,618				10.00
11.00	Home Health Aide	35,190	401,544				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	40,831	465,915				23.00
24.00	Total (sum of lines 1-23)		5,138,220				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-1
Part II
Date/Time Prepared:
2/26/2016 8:50 pm
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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	-450,293	4,687,927
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	2,090,605
7.00	Physical Therapy	0	0	0	0	0	1,266,265
8.00	Occupational Therapy	0	0	0	0	0	376,071
9.00	Speech Pathology	0	0	0	0	0	52,588
10.00	Medical Social Services	0	0	0	0	0	110,960
11.00	Home Health Aide	0	0	0	0	0	366,354
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	425,084
24.00	Total (sum of lines 1-23)	0	0	0	0	-450,293	4,687,927
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		450,293
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.096054

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-2
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIX				
	0	1.00	1.01	1.02	1.03	1.04		
1.00 Administrative and General	0	0	0	0	0	4,384	1.00	
2.00 Skilled Nursing Care	2,291,415	0	0	0	0	0	2.00	
3.00 Physical Therapy	1,387,895	0	0	0	0	0	3.00	
4.00 Occupational Therapy	412,194	0	0	0	0	0	4.00	
5.00 Speech Pathology	57,639	0	0	0	0	0	5.00	
6.00 Medical Social Services	121,618	0	0	0	0	0	6.00	
7.00 Home Health Aide	401,544	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)	465,915	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	5,138,220	0	0	0	0	4,384	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	
	MOB PHASE I	BBC	MVBLE EQUIP				
	1.05	1.06	2.00				
1.00 Administrative and General	0	0	7,249	119,147	130,780	44,020	1.00
2.00 Skilled Nursing Care	0	0	0	345,176	2,636,591	887,475	2.00
3.00 Physical Therapy	0	0	0	230,109	1,618,004	544,619	3.00
4.00 Occupational Therapy	0	0	0	66,430	478,624	161,104	4.00
5.00 Speech Pathology	0	0	0	9,347	66,986	22,547	5.00
6.00 Medical Social Services	0	0	0	28,381	149,999	50,490	6.00
7.00 Home Health Aide	0	0	0	49,013	450,557	151,657	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	83,036	548,951	184,776	19.00
20.00 Total (sum of lines 1-19) (2)	0	0	7,249	930,639	6,080,492	2,046,688	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 10/01/2014
To 09/30/2015

Worksheet H-2
Part I
Date/Time Prepared:
2/26/2016 8:50 pm
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Cost Center Description		MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	93,112	0	157,856	0	190,680	792,942	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)	93,112	0	157,856	0	190,680	792,942	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						
		MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED PRGM	PARAMED PRGM-RADIOLOGY	
		16.00	20.00	21.00	22.00	23.00	23.01	
1.00	Administrative and General	0	9,404	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)	0	9,404	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
HHA CCN: 147031

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-2
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Home Health Agency I

PPS

Cost Center Description		PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		23.02	23.03	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	1,418,794	0	1,418,794		1.00
2.00	Skilled Nursing Care	0	0	3,524,066	0	3,524,066	628,733	2.00
3.00	Physical Therapy	0	0	2,162,623	0	2,162,623	385,836	3.00
4.00	Occupational Therapy	0	0	639,728	0	639,728	114,135	4.00
5.00	Speech Pathology	0	0	89,533	0	89,533	15,974	5.00
6.00	Medical Social Services	0	0	200,489	0	200,489	35,769	6.00
7.00	Home Health Aide	0	0	602,214	0	602,214	107,442	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	733,727	0	733,727	130,905	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	9,371,174	0	9,371,174	1,418,794	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.						0.178411	21.00
Cost Center Description		Total HHA Costs						
		28.00						
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	4,152,799						2.00
3.00	Physical Therapy	2,548,459						3.00
4.00	Occupational Therapy	753,863						4.00
5.00	Speech Pathology	105,507						5.00
6.00	Medical Social Services	236,258						6.00
7.00	Home Health Aide	709,656						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	864,632						19.00
20.00	Total (sum of lines 1-19) (2)	9,371,174						20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-2
Part II
Date/Time Prepared:
2/26/2016 8:50 pm
PPS

Cost Center Description	CAPITAL RELATED COSTS						
	BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIX (SQUARE FEET)	NEW BUILDING & FIX (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	4,384	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.890152	0.000000	22.00
Cost Center Description	CAPITAL RELATED COSTS						
	BBC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	1.06	2.00	4.00	5A	5.00	6.00	
1.00 Administrative and General	0	7,296	450,293	0	130,780	4,925	1.00
2.00 Skilled Nursing Care	0	0	1,304,527	0	2,636,591	0	2.00
3.00 Physical Therapy	0	0	869,650	0	1,618,004	0	3.00
4.00 Occupational Therapy	0	0	251,060	0	478,624	0	4.00
5.00 Speech Pathology	0	0	35,324	0	66,986	0	5.00
6.00 Medical Social Services	0	0	107,260	0	149,999	0	6.00
7.00 Home Health Aide	0	0	185,234	0	450,557	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	313,819	0	548,951	0	19.00
20.00 Total (sum of lines 1-19)	0	7,296	3,517,167		6,080,492	4,925	20.00
21.00 Total cost to be allocated	0	7,249	930,639		2,046,688	93,112	21.00
22.00 Unit cost multiplier	0.000000	0.993558	0.264599		0.336599	18.905990	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140015
HHA CCN: 147031

Period: From 10/01/2014 To 09/30/2015

Worksheet H-2 Part II
Date/Time Prepared: 2/26/2016 8:50 pm

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Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	8.00	9.00	10.00	11.00	13.00	16.00	
1.00 Administrative and General	0	3,683	0	18,889	115,990	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	3,683	0	18,889	115,990	0	20.00
21.00 Total cost to be allocated	0	157,856	0	190,680	792,942	0	21.00
22.00 Unit cost multiplier	0.000000	42.860711	0.000000	10.094764	6.836296	0.000000	22.00

Cost Center Description	INTERNS & RESIDENTS							
	NURSING SCHOOL (ASSIGNED TIME)	SERVICES-SALARY & 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)
		20.00	21.00					
1.00 Administrative and General	45	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)	45	0	0	0	0	0	20.00	
21.00 Total cost to be allocated	9,404	0	0	0	0	0	21.00	
22.00 Unit cost multiplier	208.977778	0.000000	0.000000	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140015 HHA CCN: 147031	Period: From 10/01/2014 To 09/30/2015	Worksheet H-2 Part II Date/Time Prepared: 2/26/2016 8:50 pm PPS
		Home Health Agency I	

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

APPORTIONMENT OF PATIENT SERVICE COSTS					Provider CCN: 140015 HHA CCN: 147031	Period: From 10/01/2014 To 09/30/2015	Worksheet H-3 Part I Date/Time Prepared: 2/26/2016 8:50 pm	
					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	4,152,799		4,152,799	27,700	149.92	1.00
2.00	Physical Therapy	3.00	2,548,459	0	2,548,459	13,434	189.70	2.00
3.00	Occupational Therapy	4.00	753,863	0	753,863	4,233	178.09	3.00
4.00	Speech Pathology	5.00	105,507	0	105,507	586	180.05	4.00
5.00	Medical Social Services	6.00	236,258		236,258	125	1,890.06	5.00
6.00	Home Health Aide	7.00	709,656		709,656	6,137	115.64	6.00
7.00	Total (sum of lines 1-6)		8,506,542	0	8,506,542	52,215		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	3.00	4.00	5.00		
	0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	15,457			8.00
8.01	Skilled Nursing Care		99926	0	625			8.01
8.02	Skilled Nursing Care		31084	0	1			8.02
8.03	Skilled Nursing Care		50089	0	1,441			8.03
9.00	Physical Therapy		99914	0	9,200			9.00
9.01	Physical Therapy		99926	0	229			9.01
9.02	Physical Therapy		31084	0	16			9.02
9.03	Physical Therapy		50089	0	647			9.03
10.00	Occupational Therapy		99914	0	3,019			10.00
10.01	Occupational Therapy		99926	0	77			10.01
10.02	Occupational Therapy		31084	0	0			10.02
10.03	Occupational Therapy		50089	0	210			10.03
11.00	Speech Pathology		99914	0	343			11.00
11.01	Speech Pathology		99926	0	6			11.01
11.02	Speech Pathology		31084	0	0			11.02
11.03	Speech Pathology		50089	0	137			11.03
12.00	Medical Social Services		99914	0	68			12.00
12.01	Medical Social Services		99926	0	1			12.01
12.02	Medical Social Services		31084	0	0			12.02
12.03	Medical Social Services		50089	0	7			12.03
13.00	Home Health Aide		99914	0	3,923			13.00
13.01	Home Health Aide		99926	0	291			13.01
13.02	Home Health Aide		31084	0	0			13.02
13.03	Home Health Aide		50089	0	852			13.03
14.00	Total (sum of lines 8-13)			0	36,550			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	11,143	11,143	63,933	0.174292	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140015 HHA CCN: 147031	Period: From 10/01/2014 To 09/30/2015	Worksheet H-3 Part I Date/Time Prepared: 2/26/2016 8:50 pm
				Title XVIII	Home Health Agency I	PPS
Cost Center Description	Program Visits			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
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	0	17,524	0	2,627,198	1.00
2.00	Physical Therapy	0	10,092	0	1,914,452	2.00
3.00	Occupational Therapy	0	3,306	0	588,766	3.00
4.00	Speech Pathology	0	486	0	87,504	4.00
5.00	Medical Social Services	0	76	0	143,645	5.00
6.00	Home Health Aide	0	5,066	0	585,832	6.00
7.00	Total (sum of lines 1-6)	0	36,550	0	5,947,397	7.00
Cost Center Description						
		6.00	7.00	8.00	9.00	10.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
8.01	Skilled Nursing Care					8.01
8.02	Skilled Nursing Care					8.02
8.03	Skilled Nursing Care					8.03
9.00	Physical Therapy					9.00
9.01	Physical Therapy					9.01
9.02	Physical Therapy					9.02
9.03	Physical Therapy					9.03
10.00	Occupational Therapy					10.00
10.01	Occupational Therapy					10.01
10.02	Occupational Therapy					10.02
10.03	Occupational Therapy					10.03
11.00	Speech Pathology					11.00
11.01	Speech Pathology					11.01
11.02	Speech Pathology					11.02
11.03	Speech Pathology					11.03
12.00	Medical Social Services					12.00
12.01	Medical Social Services					12.01
12.02	Medical Social Services					12.02
12.03	Medical Social Services					12.03
13.00	Home Health Aide					13.00
13.01	Home Health Aide					13.01
13.02	Home Health Aide					13.02
13.03	Home Health Aide					13.03
14.00	Total (sum of lines 8-13)					14.00
Program Covered Charges						
Cost Center Description	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
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0	63,933	0	11,143	0
16.00	Cost of Drugs		0	0	0	0

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140015 HHA CCN: 147031	Period: From 10/01/2014 To 09/30/2015	Worksheet H-3 Part I Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVII I	Home Health Agency I	PPS

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	2,627,198		1.00
2.00	Physical Therapy	1,914,452		2.00
3.00	Occupational Therapy	588,766		3.00
4.00	Speech Pathology	87,504		4.00
5.00	Medical Social Services	143,645		5.00
6.00	Home Health Aide	585,832		6.00
7.00	Total (sum of lines 1-6)	5,947,397		7.00
Cost Center Description		12.00		
Limitation Cost Computation				
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140015
HHA CCN: 147031

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-3
Part II
Date/Time Prepared:
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Title XVIII

Home Health
Agency I

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	0.627586	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.426595	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.375590	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.174295	63,933	11,143	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.197512	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140015 HHA CCN: 147031	Period: From 10/01/2014 To 09/30/2015	Worksheet H-4 Part I-II Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	5,315,159	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	5,315,159	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	5,315,159	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	2,473	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	-2,473
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	4,756,092
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	276,570
13.00	Total PPS Reimbursement - LUPA Episodes		0	64,557
14.00	Total PPS Reimbursement - PEP Episodes		0	30,794
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	119,895
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	90
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	5,245,525
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	5,245,525
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	5,245,525
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	5,245,525
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	5,245,525
31.01	Sequestration adjustment (see instructions)		0	104,912
32.00	Interim payments (see instructions)		0	5,140,613
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet H-5
	HHA CCN: 147031	Home Health Agency I	Date/Time Prepared: 2/26/2016 8:50 pm 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		5,140,613	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		5,140,613	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		5,140,613	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 10/01/2014	Worksheet K
		Hospice CCN: 141501	To 09/30/2015	Date/Time Prepared: 2/26/2016 8:50 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	368,501	0	91,211	0	220,100	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	27,539	0	0	53,000	0	9.00
10.00	Nursing Care	877,201	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	178,880	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	78,587	0	0	110,244	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	160,417	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	40,641	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)	1,530,708	0	91,211	163,244	421,158	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140015

Period: From 10/01/2014

Worksheet K

Hospice CCN: 141501

To 09/30/2015

Date/Time Prepared: 2/26/2016 8:50 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	679,812	0	679,812	0	679,812	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	80,539	0	80,539	-27,539	53,000	9.00
10.00	Nursing Care	877,201	0	877,201	0	877,201	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	178,880	0	178,880	0	178,880	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	188,831	0	188,831	0	188,831	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	160,417	0	160,417	0	160,417	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	40,641	-351	40,290	0	40,290	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)	2,206,321	-351	2,205,970	-27,539	2,178,431	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015

Period: From 10/01/2014

Worksheet K-1

Hospice CCN: 141501

To 09/30/2015

Date/Time Prepared: 2/26/2016 8:50 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	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	877,201	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	178,880	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	178,880	0	877,201	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140015

Period:

Worksheet K-1

Hospice CCN: 141501

From 10/01/2014
To 09/30/2015

Date/Time Prepared:
2/26/2016 8:50 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	368,501	368,501	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	27,539	27,539	9.00
10.00	Nursing Care		0	0	877,201	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	178,880	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		78,587	0	78,587	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	78,587	396,040	1,530,708	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140015	Period: From 10/01/2014	Worksheet K-3
		Hospice CCN: 141501	To 09/30/2015	Date/Time Prepared: 2/26/2016 8:50 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	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: From 10/01/2014 To 09/30/2015	Worksheet K-3
		Hospice CCN: 141501		Date/Time Prepared: 2/26/2016 8:50 pm

		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	53,000	53,000	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		110,244	0	110,244	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	110,244	53,000	163,244	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-4
Part I
Date/Time Prepared:
2/26/2016 8:50 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	679,812	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	53,000	0	0	0	0	9.00
10.00	Nursing Care	877,201	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	178,880	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	188,831	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	160,417	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	40,290	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)	2,178,431	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 140015	Period: From 10/01/2014	Worksheet K-4
		Hospice CCN: 141501	To 09/30/2015	Part I
				Date/Time Prepared: 2/26/2016 8:50 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	679,812	679,812		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	53,000	24,042	77,042	9.00
10.00	Nursing Care	0	877,201	397,920	1,275,121	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	178,880	81,145	260,025	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	188,831	85,659	274,490	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	160,417	72,769	233,186	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	40,290	18,277	58,567	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	2,178,431		2,178,431	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2014
 To 09/30/2015

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/26/2016 8:50 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140015
 Hospice CCN: 141501

Period:
 From 10/01/2014
 To 09/30/2015

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/26/2016 8:50 pm

		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	-679,812	1,498,619	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	53,000	9.00
10.00	Nursing Care	0	877,201	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	178,880	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	188,831	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	160,417	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	40,290	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)		679,812	39.00
40.00	Unit Cost Multiplier		0.453626	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2014
To 09/30/2015

Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
		BLDG & FIXT	BUTLER BUILDING	OLD BUILDING & FIX	NEW BUILDING & FIX	
		1.00	1.01	1.02	1.03	
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	77,042	0	0	0	0	4.00
5.00 Nursing Care	1,275,121	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	260,025	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	274,490	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	233,186	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	58,567	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)	2,178,431	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 10/01/2014
 To 09/30/2015

Worksheet K-5
 Part I
 Date/Time Prepared:
 2/26/2016 8:50 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
	14TH STREET	MOB PHASE I	BBC	MVBLE EQUIP		
	1.04	1.05	1.06	2.00		
1.00 Administrative and General	0	0	0	98,252	97,505	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	232,107	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	47,331	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	20,794	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	98,252	397,737	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 10/01/2014
To 09/30/2015

Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		Hospice I					
		Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	6.00	8.00	9.00	
1.00	Administrative and General	195,757	65,892	0	4,043	27,774	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	77,042	25,932	0	0	0	4.00
5.00	Nursing Care	1,507,228	507,331	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	307,356	103,456	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	295,284	99,392	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	233,186	78,490	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	58,567	19,714	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)	2,674,420	900,207	0	4,043	27,774	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 10/01/2014
To 09/30/2015

Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		Hospice I					
		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
		10.00	11.00	13.00	16.00	20.00	
1.00	Administrative and General	0	94,376	392,472	0	7,315	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	94,376	392,472	0	7,315	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 10/01/2014

Part I

To 09/30/2015

Date/Time Prepared:

2/26/2016 8:50 pm

Cost Center Description		INTERNS & RESIDENTS		PARAMED PRGM	PARAMED PRGM-RADIOLOGY	PARAMED PRGM-LABORATORY	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
		21.00	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:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2014
To 09/30/2015

Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		PARAMED ED	Subtotal	Intern &	Subtotal	Allocated	
		PRGM-PHARMACY	(col s. 4A-23)	Residents Cost & Post Stepdown Adjustments	(col s. 24 ± 25)	Hospice I Hospice A&G (See Part II)	
		23.03	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	787,629				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	102,974	0	102,974	24,481	4.00
5.00	Nursing Care	0	2,014,559	0	2,014,559	478,943	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	410,812	0	410,812	97,666	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	394,676	0	394,676	93,830	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	311,676	0	311,676	74,098	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	78,281	0	78,281	18,611	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	4,100,607	0	4,100,607		34.00
35.00	Unit Cost Multiplier (see instructions)					0.237740	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140015

Period:

Worksheet K-5

Hospice CCN: 141501

From 10/01/2014
To 09/30/2015

Part I
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		Total Hospice Costs (cols. 26 ± 27)	Hospice I	
		28.00		
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	127,455		4.00
5.00	Nursing Care	2,493,502		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	508,478		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	488,506		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	385,774		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	96,892		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	4,100,607		34.00
35.00	Unit Cost Multiplier (see instructions)			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BUILDING & FIX (SQUARE FEET)	NEW BUILDING & FIX (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 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		MOB PHASE I (SQUARE FEET)	BBC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.05	1.06	2.00			
				98,893	368,501	5A	
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	877,201	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	178,880	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	78,587	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	98,893	1,503,169		34.00
35.00	Total cost to be allocated	0	0	98,252	397,737		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.993518	0.264599		36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	195,757	0	3,132	648	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	77,042	0	0	0	0	4.00
5.00	Nursing Care	1,507,228	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	307,356	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	295,284	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	233,186	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	58,567	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)	2,674,420	0	3,132	648	0	34.00
35.00	Total cost to be allocated	900,207	0	4,043	27,774	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.336599	0.000000	1.290868	42.861111	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description	Hospice I					
	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
	11.00	13.00	16.00	20.00	21.00	
1.00 Administrative and General	9,349	57,410	0	20	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)	9,349	57,410	0	20	0	34.00
35.00 Total cost to be allocated	94,376	392,472	0	7,315	0	35.00
36.00 Unit Cost Multiplier (see instructions)	10.094769	6.836300	0.000000	365.750000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140015
Hospice CCN: 141501

Period:
From 10/01/2014
To 09/30/2015

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 8:50 pm

Cost Center Description		Hospice I					
		INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	PARAMED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED PRGM-PHARMACY (ASSIGNED TIME)	
		SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)					
		22.00	23.00	23.01	23.02	23.03	
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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 140015	Period: From 10/01/2014	Worksheet K-5
		Hospice CCN: 141501	To 09/30/2015	Part III
		Hospice I		Date/Time Prepared: 2/26/2016 8:50 pm
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	0.627586	0
2.00	OCCUPATIONAL THERAPY	67.00	0.426595	0
3.00	SPEECH PATHOLOGY	68.00	0.375590	0
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.197512	0
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00		
6.00	LABORATORY	60.00	0.106878	0
6.01	BLOOD LABORATORY	60.01		
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.174295	0
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00		
9.00	RADIOLOGY-THERAPEUTIC	55.00		
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00		
11.00	Totals (sum of lines 1-10)			0

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140015

Period:

Worksheet K-6

Hospice CCN: 141501

From 10/01/2014

To 09/30/2015

Date/Time Prepared:
2/26/2016 8:50 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				4,100,607	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				15,806	2.00
3.00	Average cost per diem (line 1 divided by line 2)				259.43	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	14,823				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	3,845,531				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		309			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		80,164			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	8,041				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	2,086,077				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		97			10.00
11.00	Aggregate NF cost (line 3 times line 10)		25,165			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			674		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			174,856		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140015	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,323,610	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		98,869	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)		110.71	3.00
4.00	Number of interns & residents (see instructions)		16.80	4.00
5.00	Indirect medical education percentage (see instructions)		4.38	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		145,574	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 (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		3,568,053	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 HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2014 To 09/30/2015	Worksheet M-1 Date/Time Prepared: 2/26/2016 8:50 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	197,753	0	197,753	0	197,753	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	182,568	0	182,568	0	182,568	9.00
10.00	Subtotal (sum of lines 1 through 9)	380,321	0	380,321	0	380,321	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	22,944	22,944	0	22,944	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	345,948	345,948	0	345,948	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	75,468	75,468	-1,471	73,997	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	75,468	75,468	-1,471	73,997	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	380,321	421,416	801,737	-1,471	800,266	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	86,443	86,443	0	86,443	29.00
30.00	Administrative Costs	96,011	80,846	176,857	0	176,857	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	96,011	167,289	263,300	0	263,300	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	476,332	588,705	1,065,037	-1,471	1,063,566	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2014 To 09/30/2015	Worksheet M-1 Date/Time Prepared: 2/26/2016 8:50 pm
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	197,753
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	182,568
10.00	Subtotal (sum of lines 1 through 9)	0	380,321
11.00	Physician Services Under Agreement	0	323,004
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	22,944
14.00	Subtotal (sum of lines 11 through 13)	0	345,948
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	73,997
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	73,997
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	800,266
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	-43,096	43,347
30.00	Administrative Costs	-31,788	145,069
31.00	Total Facility Overhead (sum of lines 29 and 30)	-74,884	188,416
32.00	Total facility costs (sum of lines 22, 28 and 31)	-74,884	988,682

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2014 To 09/30/2015	Worksheet M-2 Date/Time Prepared: 2/26/2016 8:50 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.70	2,378	4,200	2,940	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.81	5,276	2,100	3,801	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.51	7,654		6,741	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.51	7,654			8.00
9.00	Physician Services Under Agreements		0			9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		800,266
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		800,266
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)		188,416
15.00	Parent provider overhead allocated to facility (see instructions)		502,021
16.00	Total overhead (sum of lines 14 and 15)		690,437
17.00	Allowable GME overhead (see instructions)		0
18.00	Subtotal (see instructions)		690,437
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		690,437
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		1,490,703

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140015 Component CCN: 143422	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,490,703	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		52,284	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,438,419	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,654	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,654	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		187.93	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)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	79.80	80.44	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	648	1,756	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	51,710	141,253	11.00
12.00	Program covered visits for mental health services (from contractor records)	15	34	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,197	2,735	13.00
14.00	Limit adjustment for mental health services (see instructions)	1,197	2,735	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) *		196,895	16.00
16.01	Total program charges (see instructions)(from contractor's records)		488,196	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		129,373	16.04
16.05	Total program cost (see instructions)		129,373	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		35,179	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		90,603	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		129,373	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		29,924	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		159,297	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		159,297	26.00
26.01	Sequestration adjustment (see instructions)		3,186	26.01
27.00	Interim payments		129,113	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)		26,998	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

		Provider CCN: 140015	Period:	Worksheet M-4
		Component CCN: 143422	From 10/01/2014 To 09/30/2015	Date/Time Prepared: 2/26/2016 8:50 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	380,321	380,321	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000469	0.005940	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	178	2,259	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	16,539	9,092	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	16,717	11,351	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	800,266	800,266	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	690,437	690,437	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.020889	0.014184	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	14,423	9,793	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	31,140	21,144	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	130	570	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	239.54	37.09	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	89	232	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	21,319	8,605	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		52,284	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		29,924	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 10/01/2014 To 09/30/2015	Worksheet M-5 Date/Time Prepared: 2/26/2016 8:50 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		123,969	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		09/22/2015	5,144	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		5,144	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		129,113	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		26,998	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		156,111	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00