

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/26/2016 9:24 am
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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:	Time:
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 OTTAWA REGIONAL HOSPITAL & HEALTHCARE (140110) 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	158,116	-27,887	528,230	0	1.00
2.00 Subprovider - IPF	0	11	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	158,127	-27,887	528,230	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: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 9:24 am								
1.00		2.00		3.00		4.00								
Hospital and Hospital Health Care Complex Address:														
1.00	Street: 1100 EAST NORRIS DRIVE			PO Box:						1.00				
2.00	City: OTTAWA			State: IL		Zip Code: 61350		County: LASALLE		2.00				
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)							
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00					
Hospital and Hospital-Based Component Identification:														
3.00	Hospital	OTTAWA REGIONAL HOSPITAL & HEALTHCARE		140110	16974	1	07/01/1966	N	P	O	3.00			
4.00	Subprovider - IPF	OTTAWA REGIONAL PSYCHIATRIC UNIT		14S110	16974	4	05/01/1984	N	P	O	4.00			
5.00	Subprovider - IRF										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										9.00			
10.00	Hospital-Based NF										10.00			
11.00	Hospital-Based OLTC										11.00			
12.00	Hospital-Based HHA	OTTAWA VISITING NURSING SERVICE		147048	16974		11/01/1985	N	P	N	12.00			
13.00	Separately Certified ASC										13.00			
14.00	Hospital-Based Hospice	HOSPICE OF COMMUNITY HOSPITAL		141570	16974		02/01/1984				14.00			
15.00	Hospital-Based Health Clinic - RHC										15.00			
16.00	Hospital-Based Health Clinic - FQHC										16.00			
17.00	Hospital-Based (CMHC) I										17.00			
18.00	Renal Dialysis										18.00			
19.00	Other										19.00			
						From:		To:						
						1.00		2.00						
20.00	Cost Reporting Period (mm/dd/yyyy)					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)					Y		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.							1		23.00				
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days							
		1.00	2.00	3.00	4.00	5.00	6.00							
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					3,918		355		0	0	389	142	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 9:24 am			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
		Urban/Rural		S		Date of Geogr			
		1.00		2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		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.					1	10/01/2013	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
		Beginning:		Ending:					
		1.00		2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
		Y/N		Y/N					
		1.00		2.00					
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	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	Y	40.00	
		V		XVIII		XIX			
		1.00		2.00		3.00			
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					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)					N			60.00
		Y/N		IME		Direct GME			
		1.00		2.00		3.00			
						4.00			
						5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140110

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

Worksheet S-2
Part I
Date/Time Prepared:
2/26/2016 9:24 am

		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
						1.00
<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 Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			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	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00

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		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
		1.00			
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.		N		87.00
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00			
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.	2			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	94,198	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	Y	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
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	149006	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:			142.00
143.00	City: PEORIA	State: IL		Zip Code: 61603	143.00
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
				1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.		N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
				1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 9:24 am		
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	157.00		
158.00	SUBPROVIDER					158.00		
159.00	SNF	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC	N	N	N	N	161.00		
						1.00		
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.50	169.00	
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2014	09/30/2015	170.00		
						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: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/26/2016 9:24 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		Y		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	12/23/2015	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.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/26/2016 9:24 am	
	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.	0	1.00	2.00	3.00
			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				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				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.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAWN		TROMPETER	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF SAINT ELIZABETH MEDICAL CENTER			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-431-5458		DAWN.C.TROMPETER@OSFHEALTHCARE.ORG	43.00

		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)	12/23/2015		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.		CHIEF FINANCIAL OFFICER	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: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part IX Date/Time Prepared: 2/26/2016 9:24 am
		Title V 1.00	Title XIX 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.	Y	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.	Y	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.	Y	Y	3.00
		Inpatient 1.00	Outpatient 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 1.00	Title XIX 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.	Y	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.	Y	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: 140110

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	82	29,930	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)		82	29,930	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	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					0	13.00
14.00 Total (see instructions)	43.00	87	31,755	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	8	2,920		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		95				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: 140110

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	3,479	3,226	9,647			1.00
2.00 HMO and other (see instructions)	500	744				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	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)	3,479	3,226	9,647			7.00
8.00 INTENSIVE CARE UNIT	607	336	963			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		356	1,023			13.00
14.00 Total (see instructions)	4,086	3,918	11,633	0.00	345.50	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,212	169	1,948	0.00	8.60	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	3,714	0	5,944	0.00	3.22	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	1.10	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	358.42	27.00
28.00 Observation Bed Days		0	1,722			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	142	199			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: 140110

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
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	1,237	1,313	3,330	1.00
2.00 HMO and other (see instructions)			180	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,237	1,313	3,330	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	191	30	337	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						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: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet S-3 Part II Date/Time Prepared: 2/26/2016 9:24 am	
	Worksheet A Line Number	Amount Reported	Reclassification 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	29,410,995	-197,148	29,213,847	754,910.00	38.70	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		756,349	0	756,349	3,180.00	237.85	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		2,724,540	0	2,724,540	14,043.00	194.01	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,249,833	15,602	1,265,435	30,686.00	41.24	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	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		775,259	0	775,259	4,708.00	164.67	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	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)		8,394,936	0	8,394,936			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		406,702	0	406,702			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		119,008	0	119,008			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		448,242	0	448,242			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	53,175	0	53,175	2,011.00	26.44	26.00
27.00	Administrative & General	5.00	2,517,829	-23,894	2,493,935	58,910.00	42.33	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	836,889	0	836,889	23,169.00	36.12	30.00
31.00	Laundry & Linen Service	8.00	35,562	0	35,562	2,197.00	16.19	31.00
32.00	Housekeeping	9.00	769,711	0	769,711	43,999.00	17.49	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	723,217	0	723,217	37,728.00	19.17	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	776,793	0	776,793	14,988.00	51.83	38.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140110

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

Worksheet S-3
Part II
Date/Time Prepared:
2/26/2016 9:24 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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		
39.00	Central Services and Supply	14.00	218,148	0	218,148	11,108.00	19.64	39.00
40.00	Pharmacy	15.00	938,634	0	938,634	18,454.00	50.86	40.00
41.00	Medical Records & Medical Records Library	16.00	1,367,175	0	1,367,175	44,144.00	30.97	41.00
42.00	Social Service	17.00	82,856	0	82,856	1,330.00	62.30	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140110

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

Worksheet S-3
Part III
Date/Time Prepared:
2/26/2016 9:24 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hours Rel ated to Sal ari es i n 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)	26,686,455	-197,148	26,489,307	740,867.00	35.75	1.00
2.00	Excluded area salaries (see instructions)	1,249,833	15,602	1,265,435	30,686.00	41.24	2.00
3.00	Subtotal salaries (line 1 minus line 2)	25,436,622	-212,750	25,223,872	710,181.00	35.52	3.00
4.00	Subtotal other wages & related costs (see inst.)	775,259	0	775,259	4,708.00	164.67	4.00
5.00	Subtotal wage-related costs (see inst.)	8,513,944	0	8,513,944	0.00	33.75	5.00
6.00	Total (sum of lines 3 thru 5)	34,725,825	-212,750	34,513,075	714,889.00	48.28	6.00
7.00	Total overhead cost (see instructions)	8,319,989	-23,894	8,296,095	258,038.00	32.15	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2016 9:24 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,588,449 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)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			5,248,961 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)			-15,799 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			355,421 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			2,096,805 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (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			95,050 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			9,368,887 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140110

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

Worksheet S-3
Part V
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			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			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			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140110 Component CCN: 147048		Period: From 10/01/2014 To 09/30/2015		Worksheet S-4 Date/Time Prepared: 2/26/2016 9:24 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	231.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.52	0.00	1.52	5.00
6.00	Direct Nursing Service			3.51	0.00	3.51	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.94	0.00	1.94	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.05	0.00	0.05	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.69	0.00	0.69	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.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974			20.00
20.01				20994			20.01
20.02				99914			20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,615	55	66	249	1,985	21.00
22.00	Skilled Nursing Visit Charges	449,681	15,953	18,123	57,748	541,505	22.00
23.00	Physical Therapy Visits	1,097	9	21	109	1,236	23.00
24.00	Physical Therapy Visit Charges	303,389	2,637	5,787	26,325	338,138	24.00
25.00	Occupational Therapy Visits	72	0	0	19	91	25.00
26.00	Occupational Therapy Visit Charges	20,136	0	0	4,487	24,623	26.00
27.00	Speech Pathology Visits	15	0	0	3	18	27.00
28.00	Speech Pathology Visit Charges	4,227	0	0	753	4,980	28.00
29.00	Medical Social Service Visits	35	2	1	2	40	29.00
30.00	Medical Social Service Visit Charges	10,241	586	293	584	11,704	30.00
31.00	Home Health Aide Visits	225	16	1	102	344	31.00
32.00	Home Health Aide Visit Charges	36,034	2,708	174	11,668	50,584	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,059	82	89	484	3,714	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)	823,708	21,884	24,377	101,565	971,534	35.00
36.00	Total Number of Episodes (standard/non outlier)	212		35	24	271	36.00
37.00	Total Number of Outlier Episodes		2		2	4	37.00
38.00	Total Non-Routine Medical Supply Charges	86,857	7,975	673	34,675	130,180	38.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 140110 Component CCN: 141570	Period: From 10/01/2014 To 09/30/2015	Worksheet S-9 Parts I & II Date/Time Prepared: 2/26/2016 9:24 am
		Hospice I		

	Unduplicated Days	Hospice I				Total (sum of cols. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility		
		1.00	2.00	3.00	4.00		
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	2,492	884	0	781	1,096	2.00
3.00	Inpatient Respite Care	6	3	0	0	8	3.00
4.00	General Inpatient Care	63	18	0	0	8	4.00
5.00	Total Hospice Days	2,561	905	0	781	1,112	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	189	10	0	8	0	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)	13.55	90.50	0.00	97.63	0.00	8.00
9.00	Unduplicated Census Count	189	10	0	8	0	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet S-10 Date/Time Prepared: 2/26/2016 9:24 am
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.266411		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		11,121,697		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		53,151,333		6.00
7.00	Medicaid cost (line 1 times line 6)		14,160,100		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)		3,038,403		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)		3,038,403		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	1,560,203	3,949,789	5,509,992	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	415,655	1,052,267	1,467,922	21.00
22.00	Partial payment by patients approved for charity care	25,890	82,880	108,770	22.00
23.00	Cost of charity care (line 21 minus line 22)	389,765	969,387	1,359,152	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)		3,321,951		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		338,080		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,983,871		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		794,936		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,154,088		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,192,491		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140110

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

Worksheet A
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		985,096	985,096	60,449	1,045,545	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,081,168	3,081,168	33,764	3,114,932	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	53,175	9,151,573	9,204,748	0	9,204,748	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,517,829	14,346,678	16,864,507	-153,915	16,710,592	5.00
7.00	00700	OPERATION OF PLANT	836,889	806,873	1,643,762	-16,496	1,627,266	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,562	216,745	252,307	0	252,307	8.00
9.00	00900	HOUSEKEEPING	769,711	154,257	923,968	109	924,077	9.00
10.00	01000	DIETARY	723,217	723,041	1,446,258	0	1,446,258	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	776,793	64,350	841,143	0	841,143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	218,148	521,913	740,061	-260,976	479,085	14.00
15.00	01500	PHARMACY	938,634	2,158,697	3,097,331	-2,101,281	996,050	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,367,175	174,338	1,541,513	0	1,541,513	16.00
17.00	01700	SOCIAL SERVICE	82,856	3,281	86,137	0	86,137	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	197,148	197,148	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,936,539	1,466,539	6,403,078	-1,421,153	4,981,925	30.00
31.00	03100	INTENSIVE CARE UNIT	785,418	248,479	1,033,897	0	1,033,897	31.00
40.00	04000	SUBPROVIDER - IPF	548,173	3,622	551,795	15,602	567,397	40.00
43.00	04300	NURSERY	0	0	0	215,386	215,386	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	760,706	2,888,039	3,648,745	-1,310,810	2,337,935	50.00
51.00	05100	RECOVERY ROOM	319,981	823	320,804	0	320,804	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	936,964	936,964	52.00
53.00	05300	ANESTHESIOLOGY	1,722,463	142,343	1,864,806	-275,984	1,588,822	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,114,682	1,331,460	3,446,142	-767,140	2,679,002	54.00
58.00	05800	MRI	0	0	0	216,045	216,045	58.00
60.00	06000	LABORATORY	1,153,592	1,583,928	2,737,520	0	2,737,520	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	441,167	165,745	606,912	-115,059	491,853	65.00
66.00	06600	PHYSICAL THERAPY	1,785,351	194,757	1,980,108	0	1,980,108	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,396	79	145,475	0	145,475	67.00
68.00	06800	SPEECH PATHOLOGY	38,718	89	38,807	-3,408	35,399	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	96,984	96,984	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,478	1,478	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,204,023	2,204,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	734,478	734,478	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,101,281	2,101,281	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,336,803	694,526	2,031,329	-651,424	1,379,905	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,041,198	53,836	2,095,034	-54,233	2,040,801	76.01
76.02	03610	SLEEP LAB	127,995	31,255	159,250	9,831	169,081	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	345,435	345,435	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,131,164	1,017,317	3,148,481	-93,650	3,054,831	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	581,018	101,057	682,075	9,145	691,220	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	117,623	226,637	344,260	622	344,882	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,407,976	42,538,541	71,946,517	-46,785	71,899,732	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,019	1,101,217	1,104,236	46,785	1,151,021	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	29,410,995	43,639,758	73,050,753	0	73,050,753	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140110

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

Worksheet A
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	3,701,651	4,747,196	1.00
2.00	00200	0	3,114,932	2.00
3.00	00300	0	0	3.00
4.00	00400	-1,757	9,202,991	4.00
5.00	00500	-6,277,118	10,433,474	5.00
7.00	00700	0	1,627,266	7.00
8.00	00800	0	252,307	8.00
9.00	00900	0	924,077	9.00
10.00	01000	-427,198	1,019,060	10.00
11.00	01100	0	0	11.00
13.00	01300	-1,000	840,143	13.00
14.00	01400	0	479,085	14.00
15.00	01500	0	996,050	15.00
16.00	01600	-295	1,541,218	16.00
17.00	01700	0	86,137	17.00
19.00	01900	-197,148	0	19.00
23.00	02300	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	-891,093	4,090,832	30.00
31.00	03100	-126,152	907,745	31.00
40.00	04000	0	567,397	40.00
43.00	04300	0	215,386	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	2,337,935	50.00
51.00	05100	0	320,804	51.00
52.00	05200	0	936,964	52.00
53.00	05300	-1,273,693	315,129	53.00
54.00	05400	0	2,679,002	54.00
58.00	05800	0	216,045	58.00
60.00	06000	0	2,737,520	60.00
64.00	06400	0	0	64.00
65.00	06500	-398	491,455	65.00
66.00	06600	-33,084	1,947,024	66.00
67.00	06700	0	145,475	67.00
68.00	06800	0	35,399	68.00
69.00	06900	-105	96,879	69.00
70.00	07000	0	1,478	70.00
71.00	07100	0	2,204,023	71.00
72.00	07200	0	734,478	72.00
73.00	07300	-4,382	2,096,899	73.00
75.00	07500	0	1,379,905	75.00
76.00	03160	0	0	76.00
76.01	03550	-1,180,752	860,049	76.01
76.02	03610	0	169,081	76.02
76.97	07697	0	345,435	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	-1,120,833	1,933,998	91.00
92.00	09200	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	0	691,220	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	0	0	113.00
116.00	11600	-8,020	336,862	116.00
117.00	06950	0	0	117.00
118.00		-7,841,377	64,058,355	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
192.00	19200	0	1,151,021	192.00
194.00	07950	0	0	194.00
200.00		-7,841,377	65,209,376	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet Non-CMS W Date/Time Prepared: 2/26/2016 9:24 am
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
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
7.00	OPERATION OF PLANT	00700		7.00
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
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23.00
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
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
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 PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
75.00	ASC (NON-DISTINCT PART)	07500		75.00
76.00	STRESS TESTING	03160	CARDIOPULMONARY	76.00
76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01
76.02	SLEEP LAB	03610	SLEEP LAB	76.02
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
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
117.00	HOMEMAKER	06950		117.00
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
194.00	CARDINAL SLEEP	07950		194.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140110

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

Worksheet A-6
Date/Time Prepared:
2/26/2016 9:24 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	60,449	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,764	2.00
	O		0	94,213	
B - DELIVERY ROOM AND NURSERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	923,380	182,084	1.00
2.00	NURSERY	43.00	179,909	35,477	2.00
	O		1,103,289	217,561	
C - EKG HOLTER, STRESS, EEG					
1.00	ELECTROCARDIOLOGY	69.00	96,879	105	1.00
2.00	CARDIAC REHABILITATION	76.97	83,951	261,484	2.00
3.00	ELECTROENCEPHALOGRAPHY	70.00	1,478		3.00
	O		182,308	261,589	
D - ER WARD CLERKS					
1.00	EMERGENCY	91.00	23,894	0	1.00
	O		23,894	0	
I - C-SECTION					
1.00	OPERATING ROOM	50.00	140,746	27,754	1.00
	O		140,746	27,754	
K - NONPHYSICIAN ANESTHETISTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	197,148	1.00
	O		0	197,148	
M - MOB HOSPITAL STORAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,015	1.00
	O		0	20,015	
O - PSYCH ADMIN					
1.00	ADULTS & PEDIATRICS	30.00	38,631	0	1.00
2.00	SUBPROVIDER - IPF	40.00	15,602	0	2.00
	O		54,233	0	
U - NORRIS BUILDING					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	87,394	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
	O		0	87,394	
V - MERCURY CIRCLE BUILDING					
1.00	HOUSEKEEPING	9.00	0	109	1.00
2.00	HOME HEALTH AGENCY	101.00	0	9,145	2.00
3.00	HOSPICE	116.00	0	622	3.00
4.00	SLEEP LAB	76.02	0	9,831	4.00
	O		0	19,707	
W - RADIOLOGY SPACE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	887	1.00
	O		0	887	
AA - EMS					
1.00		0.00	0	0	1.00
	O		0	0	
AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,204,023	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	734,478	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,101,281	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
	O		0	5,039,782	
AC - NEG SALARIES					
1.00		0.00	0	0	1.00
	O		0	0	
AD - MRI SALARIES					
1.00	MRI	58.00	204,175	11,870	1.00
	O		204,175	11,870	
500.00	Grand Total: Increases		1,708,645	5,977,920	500.00

RECLASSIFICATIONS

Provider CCN: 140110

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

Worksheet A-6
Date/Time Prepared:
2/26/2016 9:24 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	94,213	12		1.00
2.00		0.00	0	0	12		2.00
	O			94,213			
B - DELIVERY ROOM AND NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	1,103,289	217,561	0		1.00
2.00		0.00	0	0	0		2.00
	O		1,103,289	217,561			
C - EKG HOLTER, STRESS, EEG							
1.00	ASC (NON-DISTINCT PART)	75.00	182,308	261,589	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	O		182,308	261,589			
D - ER WARD CLERKS							
1.00	ADMINISTRATIVE & GENERAL	5.00	23,894	0	0		1.00
	O		23,894	0			
I - C-SECTION							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	140,746	27,754	0		1.00
	O		140,746	27,754			
K - NONPHYSICIAN ANESTHETISTS							
1.00	ANESTHESIOLOGY	53.00	197,148	0	0		1.00
	O		197,148	0			
M - MOB HOSPITAL STORAGE							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	20,015	0		1.00
	O		0	20,015			
O - PSYCH ADMIN							
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	54,233	0	0		1.00
2.00		0.00	0	0	0		2.00
	O		54,233	0			
U - NORRIS BUILDING							
1.00	OPERATION OF PLANT	7.00	0	16,496	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	3,408	0		2.00
3.00	ASC (NON-DISTINCT PART)	75.00	0	11,667	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	55,823	0		4.00
	O		0	87,394			
V - MERCURY CIRCLE BUILDING							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	19,707	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	O		0	19,707			
W - RADIOLOGY SPACE							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	887	0		1.00
	O		0	887			
AA - EMS							
1.00		0.00	0	0	0		1.00
	O		0	0			
AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	260,976	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	138,934	0		2.00
3.00	OPERATING ROOM	50.00	0	744,832	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	78,836	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	551,982	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	115,059	0		6.00
7.00	ASC (NON-DISTINCT PART)	75.00	0	195,860	0		7.00
8.00	EMERGENCY	91.00	0	117,544	0		8.00
9.00	OPERATING ROOM	50.00	0	734,478	0		9.00
10.00	PHARMACY	15.00	0	2,101,281	0		10.00
	O		0	5,039,782			
AC - NEG SALARIES							
1.00		0.00	0	0	0		1.00
	O		0	0			
AD - MRI SALARIES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	204,175	11,870	0		1.00
	O		204,175	11,870			
500.00	Grand Total: Decreases		1,905,793	5,780,772			500.00

RECLASSIFICATIONS

Provider CCN: 140110

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
2/26/2016 9:24 am

		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 - INSURANCE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	60,449	ADMINISTRATIVE & GENERAL	5.00	0	94,213	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	33,764		0.00	0	0	2.00
			0	94,213			0	94,213	
B - DELIVERY ROOM AND NURSERY									
1.00	DELIVERY ROOM & LABOR ROOM	52.00	923,380	182,084	ADULTS & PEDIATRICS	30.00	1,103,289	217,561	1.00
2.00	NURSERY	43.00	179,909	35,477		0.00	0	0	2.00
			1,103,289	217,561			1,103,289	217,561	
C - EKG HOLTER, STRESS, EEG									
1.00	ELECTROCARDIOLOGY	69.00	96,879	105	ASC (NON-DI STINCT PART)	75.00	182,308	261,589	1.00
2.00	CARDIAC REHABILITATION	76.97	83,951	261,484		0.00	0	0	2.00
3.00	ELECTROENCEPHALOGRAPHY	70.00	1,478			0.00	0	0	3.00
			182,308	261,589			182,308	261,589	
D - ER WARD CLERKS									
1.00	EMERGENCY	91.00	23,894	0	ADMINISTRATIVE & GENERAL	5.00	23,894	0	1.00
			23,894	0			23,894	0	
I - C-SECTION									
1.00	OPERATING ROOM	50.00	140,746	27,754	DELIVERY ROOM & LABOR ROOM	52.00	140,746	27,754	1.00
			140,746	27,754			140,746	27,754	
K - NONPHYSICIAN ANESTHETISTS									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	197,148	ANESTHESIOLOGY	53.00	197,148	0	1.00
			0	197,148			197,148	0	
M - MOB HOSPITAL STORAGE									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,015	PHYSICIANS' PRIVATE OFFICES	192.00	0	20,015	1.00
			0	20,015			0	20,015	
O - PSYCH ADMIN									
1.00	ADULTS & PEDIATRICS	30.00	38,631	0	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	54,233	0	1.00
2.00	SUBPROVIDER - IPF	40.00	15,602	0		0.00	0	0	2.00
			54,233	0			54,233	0	
U - NORRIS BUILDING									
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	87,394	OPERATION OF PLANT	7.00	0	16,496	1.00
2.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	3,408	2.00
3.00		0.00	0	0	ASC (NON-DI STINCT PART)	75.00	0	11,667	3.00
4.00		0.00	0	0	ADMINISTRATIVE & GENERAL	5.00	0	55,823	4.00
			0	87,394			0	87,394	
V - MERCURY CIRCLE BUILDING									
1.00	HOUSEKEEPING	9.00	0	109	PHYSICIANS' PRIVATE OFFICES	192.00	0	19,707	1.00
2.00	HOME HEALTH AGENCY	101.00	0	9,145		0.00	0	0	2.00
3.00	HOSPICE	116.00	0	622		0.00	0	0	3.00
4.00	SLEEP LAB	76.02	0	9,831		0.00	0	0	4.00
			0	19,707			0	19,707	
W - RADIOLOGY SPACE									
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	887	PHYSICIANS' PRIVATE OFFICES	192.00	0	887	1.00
			0	887			0	887	
AA - EMS									
1.00		0.00	0	0		0.00	0	0	1.00
			0	0			0	0	
AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,204,023	CENTRAL SERVICES & SUPPLY	14.00	0	260,976	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	734,478	ADULTS & PEDIATRICS	30.00	0	138,934	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,101,281	OPERATING ROOM	50.00	0	744,832	3.00
4.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	78,836	4.00
5.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	551,982	5.00
6.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	115,059	6.00
7.00		0.00	0	0	ASC (NON-DI STINCT PART)	75.00	0	195,860	7.00

Provider CCN: 140110

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
2/26/2016 9:24 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00		4.00	5.00	6.00	7.00	8.00	9.00	
8.00		0.00	0	0	EMERGENCY	91.00	0	117,544	8.00
9.00		0.00	0	0	OPERATING ROOM	50.00	0	734,478	9.00
10.00		0.00	0	0	PHARMACY	15.00	0	2,101,281	10.00
			0	5,039,782			0	5,039,782	
AC - NEG SALARIES									
1.00		0.00	0	0		0.00	0	0	1.00
			0	0			0	0	
AD - MRI SALARIES									
1.00	MRI	58.00	204,175	11,870	RADIOLOGY-DIAGNOSTIC	54.00	204,175	11,870	1.00
			204,175	11,870			204,175	11,870	
500.00	Grand Total :		1,708,645	5,977,920	Grand Total :		1,905,793	5,780,772	500.00
	Increases				Decreases				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140110

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

Worksheet A-7
Part I
Date/Time Prepared:
2/26/2016 9:24 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,128,395	2,716	0	2,716	0	1.00
2.00	Land Improvements	2,862,859	0	0	0	0	2.00
3.00	Buildings and Fixtures	73,755,026	430,595	0	430,595	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	40,512,415	4,660,528	0	4,660,528	0	6.00
7.00	HIT designated Assets	694,477	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	120,953,172	5,093,839	0	5,093,839	0	8.00
9.00	Reconciling Items	4,800,729	3,027,229	0	3,027,229	0	9.00
10.00	Total (line 8 minus line 9)	116,152,443	2,066,610	0	2,066,610	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,131,111	0				1.00
2.00	Land Improvements	2,862,859	0				2.00
3.00	Buildings and Fixtures	74,185,621	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	45,172,943	0				6.00
7.00	HIT designated Assets	694,477	0				7.00
8.00	Subtotal (sum of lines 1-7)	126,047,011	0				8.00
9.00	Reconciling Items	7,827,958	0				9.00
10.00	Total (line 8 minus line 9)	118,219,053	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140110

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

Worksheet A-7
Part II
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	985,096	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,081,168	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,066,264	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	985,096				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,081,168				2.00
3.00	Total (sum of lines 1-2)	0	4,066,264				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140110

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

Worksheet A-7
Part III
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	80,874,068	0	80,874,068	0.641618	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	45,172,943	0	45,172,943	0.358382	0	2.00
3.00	Total (sum of lines 1-2)	126,047,011	0	126,047,011	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,343,490	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,081,168	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,424,658	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,343,257	60,449	0	0	4,747,196	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	33,764	0	0	3,114,932	2.00
3.00	Total (sum of lines 1-2)	1,343,257	94,213	0	0	7,862,128	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			3.00	4.00	5.00	
1.00	2.00	3.00	4.00	5.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP 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	-3,082	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	-79,517	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-4,499,958			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,320,536			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-427,198	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees 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	B	-4,382	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	183	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-197,148	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 AMORTIZED CAPITALIZED INTEREST	A	-33,754	CAP REL COSTS-BLDG & FIXT	1.00		11	33.00
33.01 PHYSICIAN RECRUITING EXPENSE	A	-1,757	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.01
33.02 TRUSTEE FEES	A	0		0.00		0	33.02
33.03 ADMINISTRATION ALCOHOL	A	5,428	ADMINISTRATIVE & GENERAL	5.00		0	33.03
33.04 DUES & SUBSCRIPTIONS	A	-398	ADMINISTRATIVE & GENERAL	5.00		0	33.04
33.05 ADVERTISING	A	-2,700	ADMINISTRATIVE & GENERAL	5.00		0	33.05
33.06 AHA LOBBYING FEES	A	-275,271	ADMINISTRATIVE & GENERAL	5.00		0	33.06
33.07 IHA LOBBYING FEES	A	-958	ADMINISTRATIVE & GENERAL	5.00		0	33.07
33.08 PATIENT TRANSPORTATION	A	-27,145	ADMINISTRATIVE & GENERAL	5.00		0	33.08
33.09 ROTARY FEES	A	0		0.00		0	33.09
33.10 CONTRIBUTIONS / DONATIONS	A	-15,293	ADMINISTRATIVE & GENERAL	5.00		0	33.10
33.11 PHYSICIAN RELATED COST	A	-950	ADMINISTRATIVE & GENERAL	5.00		0	33.11
33.12 MEDICAID TAX ASSESSMENT - APPEAL	A	0		0.00		0	33.12
33.13 COMMUNITY EDUCATION REVENUE	A	-7,000	ADMINISTRATIVE & GENERAL	5.00		0	33.13
33.14 COMMUNITY EDUCATION REVENUE	A	-2,217	ADMINISTRATIVE & GENERAL	5.00		0	33.14
33.15 COMMUNITY EDUCATION REVENUE	A	-2,578,172	ADMINISTRATIVE & GENERAL	5.00		0	33.15
33.16 MISCELLANEOUS REVENUE	B	-1,126	ADMINISTRATIVE & GENERAL	5.00		0	33.16
33.17 MISCELLANEOUS REVENUE	B	-20,461	ADMINISTRATIVE & GENERAL	5.00		0	33.17
33.18 MISCELLANEOUS REVENUE	B	-398	MEDICAL RECORDS & LIBRARY	16.00		0	33.18
33.19 MISCELLANEOUS REVENUE	B	0		0.00		0	33.19
33.20 MISCELLANEOUS REVENUE	B	-53,153	ADMINISTRATIVE & GENERAL	5.00		0	33.20
33.21 MISCELLANEOUS REVENUE	B	-1,000	NURSING ADMINISTRATION	13.00		0	33.21
33.22 MISCELLANEOUS REVENUE	B	-379,579	ADMINISTRATIVE & GENERAL	5.00		0	33.22
33.23 MISCELLANEOUS REVENUE	B	-80	MEDICAL RECORDS & LIBRARY	16.00		0	33.23
33.24 INTEREST/INVESTMENT INCOME OFFSET	B	-264,129	CAP REL COSTS-BLDG & FIXT	1.00		11	33.24
33.25 ASSET REDUCTION ADD-BACK	A	2,358,394	CAP REL COSTS-BLDG & FIXT	1.00		9	33.25
33.26 HOSPICE PHYSICIAN FEES	A	0		0.00		0	33.26
33.27 TOTAL (sum of lines 1 thru 49)		0		0.00		0	33.27
(Transfer to Worksheet A, column 6, line 200.)		-7,841,377	HOSPICE	116.00		0	33.28
50.00							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: 140110

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

Worksheet A-8-1

Date/Time Prepared:
2/26/2016 9:24 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00		0	0	1.00
2.00	0.00		0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL CORPORATE ALLOCATIONS	0	10,717,885	3.00
4.00	31.00	INTENSIVE CARE UNIT EICU	0	126,152	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT INTEREST EXPENSE	1,641,140	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL NONCAPITAL EXPENSE	1,059,204	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL NEW BLDG EXPENSE	210,425	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL NEW MME EXPENSE	961,254	0	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL NONCAPITAL EXPENSE	5,651,478	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		9,523,501	10,844,037	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	B	0.00	OSF HEALTHCARE	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				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: 140110

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

Worksheet A-8-1

Date/Time Prepared:
2/26/2016 9:24 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	-10,717,885	0		3.00
4.00	-126,152	0		4.00
4.01	1,641,140	11		4.01
4.02	1,059,204	0		4.02
4.03	210,425	0		4.03
4.04	961,254	0		4.04
4.05	5,651,478	0		4.05
5.00	-1,320,536			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140110

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

Worksheet A-8-2
Date/Time Prepared:
2/26/2016 9:24 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	212,816	202,325	10,491	154,100	40	1.00
2.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	205,191	195,076	10,115	154,100	40	2.00
3.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	301,826	286,947	14,879	154,100	40	3.00
4.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	470,653	447,452	23,201	154,100	40	4.00
5.00	53.00	ANESTHESIOLOGY	373,977	234,638	139,339	200,300	614	5.00
6.00	53.00	ANESTHESIOLOGY	348,753	297,349	51,404	200,300	239	6.00
7.00	53.00	ANESTHESIOLOGY	347,822	225,227	122,595	200,300	572	7.00
8.00	53.00	ANESTHESIOLOGY	210,630	192,632	17,998	200,300	83	8.00
9.00	53.00	ANESTHESIOLOGY	216,886	36,840	180,046	200,300	822	9.00
10.00	91.00	EMERGENCY	722,990	536,709	186,281	177,200	690	10.00
11.00	91.00	EMERGENCY	69,345	69,345	0	177,200	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	910,517	880,517	30,000	177,200	228	12.00
13.00	60.00	LABORATORY	113,061	0	113,061	215,700	1,874	13.00
14.00	69.00	ELECTROCARDIOLOGY	105	105	0	177,200	0	14.00
15.00	65.00	RESPIRATORY THERAPY	1,250	0	1,250	177,200	10	15.00
16.00	66.00	PHYSICAL THERAPY	46,800	0	46,800	177,200	161	16.00
17.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,118	2,118	0	154,100	0	17.00
18.00	91.00	EMERGENCY	425,377	0	425,377	177,200	2,351	18.00
19.00	91.00	EMERGENCY	188,771	0	188,771	177,200	312	19.00
200.00			5,168,888	3,607,280	1,561,608		8,116	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,963	148	0	0	0	1.00
2.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,963	148	0	0	0	2.00
3.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,963	148	0	0	0	3.00
4.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,963	148	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	59,127	2,956	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	23,015	1,151	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	55,083	2,754	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	7,993	400	0	0	0	8.00
9.00	53.00	ANESTHESIOLOGY	79,157	3,958	0	0	0	9.00
10.00	91.00	EMERGENCY	58,783	2,939	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
12.00	30.00	ADULTS & PEDIATRICS	19,424	971	0	0	0	12.00
13.00	60.00	LABORATORY	194,338	9,717	0	0	0	13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	14.00
15.00	65.00	RESPIRATORY THERAPY	852	43	0	0	0	15.00
16.00	66.00	PHYSICAL THERAPY	13,716	686	0	0	0	16.00
17.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	17.00
18.00	91.00	EMERGENCY	200,287	10,014	0	0	0	18.00
19.00	91.00	EMERGENCY	26,580	1,329	0	0	0	19.00
200.00			750,207	37,510	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,963	7,528	209,853	1.00
2.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,963	7,152	202,228	2.00
3.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,963	11,916	298,863	3.00
4.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,963	20,238	467,690	4.00
5.00	53.00	ANESTHESIOLOGY	0	59,127	80,212	314,850	5.00
6.00	53.00	ANESTHESIOLOGY	0	23,015	28,389	325,738	6.00
7.00	53.00	ANESTHESIOLOGY	0	55,083	67,512	292,739	7.00
8.00	53.00	ANESTHESIOLOGY	0	7,993	10,005	202,637	8.00
9.00	53.00	ANESTHESIOLOGY	0	79,157	100,889	137,729	9.00
10.00	91.00	EMERGENCY	0	58,783	127,498	664,207	10.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140110

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

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	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		
11.00	91.00	EMERGENCY	0	0	0	69,345		11.00
12.00	30.00	ADULTS & PEDIATRICS	0	19,424	10,576	891,093		12.00
13.00	60.00	LABORATORY	0	194,338	0	0		13.00
14.00	69.00	ELECTROCARDIOLOGY	0	0	0	105		14.00
15.00	65.00	RESPIRATORY THERAPY	0	852	398	398		15.00
16.00	66.00	PHYSICAL THERAPY	0	13,716	33,084	33,084		16.00
17.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	2,118		17.00
18.00	91.00	EMERGENCY	0	200,287	225,090	225,090		18.00
19.00	91.00	EMERGENCY	0	26,580	162,191	162,191		19.00
200.00			0	750,207	892,678	4,499,958		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,747,196	4,747,196			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,114,932		3,114,932		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,202,991	27,999	592	9,231,582	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,433,474	317,823	524,537	789,520	12,065,354 5.00
7.00 00700	OPERATION OF PLANT	1,627,266	1,769,167	52,686	264,939	3,714,058 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	252,307	23,660	0	11,258	287,225 8.00
9.00 00900	HOUSEKEEPING	924,077	42,049	2,394	243,672	1,212,192 9.00
10.00 01000	DIETARY	1,019,060	199,573	9,754	228,953	1,457,340 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	840,143	29,739	12,907	245,914	1,128,703 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	479,085	117,897	133,757	69,060	799,799 14.00
15.00 01500	PHARMACY	996,050	30,521	64,919	297,149	1,388,639 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,541,218	95,044	5,013	432,815	2,074,090 16.00
17.00 01700	SOCIAL SERVICE	86,137	17,632	48	26,230	130,047 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,090,832	555,005	163,368	1,225,758	6,034,963 30.00
31.00 03100	INTENSIVE CARE UNIT	907,745	48,355	7,895	248,644	1,212,639 31.00
40.00 04000	SUBPROVIDER - IPF	567,397	64,019	25,774	178,478	835,668 40.00
43.00 04300	NURSERY	215,386	0	0	56,955	272,341 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,337,935	174,046	394,318	285,378	3,191,677 50.00
51.00 05100	RECOVERY ROOM	320,804	18,666	3,024	101,298	443,792 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	936,964	0	0	247,763	1,184,727 52.00
53.00 05300	ANESTHESIOLOGY	315,129	0	10,279	482,878	808,286 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,679,002	169,581	701,270	604,821	4,154,674 54.00
58.00 05800	MRI	216,045	52,971	0	64,637	333,653 58.00
60.00 06000	LABORATORY	2,737,520	159,088	36,238	365,200	3,298,046 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	491,455	29,891	22,490	139,663	683,499 65.00
66.00 06600	PHYSICAL THERAPY	1,947,024	381,211	60,507	565,199	2,953,941 66.00
67.00 06700	OCCUPATIONAL THERAPY	145,475	21,440	0	46,029	212,944 67.00
68.00 06800	SPEECH PATHOLOGY	35,399	12,057	7,402	12,257	67,115 68.00
69.00 06900	ELECTROCARDIOLOGY	96,879	0	0	30,670	127,549 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,478	0	0	468	1,946 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,204,023	0	0	0	2,204,023 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	734,478	0	0	0	734,478 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,096,899	0	0	0	2,096,899 73.00
75.00 07500	ASC (NON-DISTINCT PART)	1,379,905	208,578	93,781	365,485	2,047,749 75.00
76.00 03160	STRESS TESTING	0	0	0	0	0 76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	860,049	80,313	42,975	629,025	1,612,362 76.01
76.02 03610	SLEEP LAB	169,081	0	31,175	40,520	240,776 76.02
76.97 07697	CARDIAC REHABILITATION	345,435	0	0	26,577	372,012 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	1,933,998	100,871	69,596	682,240	2,786,705 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	691,220	0	34,973	183,936	910,129 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	336,862	0	631	37,237	374,730 116.00
117.00 06950	HOMEMAKER	0	0	0	0	0 117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	64,058,355	4,747,196	2,512,303	9,230,626	63,454,770 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,151,021	0	602,629	956	1,754,606 192.00
194.00 07950	CARDINAL SLEEP	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	65,209,376	4,747,196	3,114,932	9,231,582	65,209,376 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

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

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Part I
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	12,065,354				5.00	
7.00	00700	OPERATION OF PLANT	843,206	4,557,264			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	65,209	40,964	393,398		8.00	
9.00	00900	HOUSEKEEPING	275,205	72,801	0	1,560,198	9.00	
10.00	01000	DIETARY	330,861	345,530	0	121,322	10.00	
11.00	01100	CAFETERIA	0	0	0	1,753,138	11.00	
13.00	01300	NURSING ADMINISTRATION	256,251	51,489	0	18,079	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	181,579	204,121	0	71,671	14.00	
15.00	01500	PHARMACY	315,264	52,843	0	18,554	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	470,883	164,555	0	57,778	16.00	
17.00	01700	SOCIAL SERVICE	29,525	30,526	0	10,718	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
23.00	02300	PARAMED ED PRGM - (SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,370,135	960,906	165,968	337,394	387,246	30.00
31.00	03100	INTENSIVE CARE UNIT	275,307	83,718	17,701	29,395	22,729	31.00
40.00	04000	SUBPROVIDER - IPF	189,723	110,839	3,279	38,918	91,940	40.00
43.00	04300	NURSERY	61,830	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	724,610	301,334	19,547	105,804	0	50.00
51.00	05100	RECOVERY ROOM	100,755	32,317	0	11,347	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	268,970	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	183,506	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	943,240	293,604	17,916	103,090	0	54.00
58.00	05800	MRI	75,750	91,710	0	32,201	0	58.00
60.00	06000	LABORATORY	748,759	275,437	0	96,711	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	155,175	51,751	0	18,171	0	65.00
66.00	06600	PHYSICAL THERAPY	670,636	660,009	43,391	231,742	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	48,345	37,121	0	13,034	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,237	20,875	0	7,330	0	68.00
69.00	06900	ELECTROCARDIOLOGY	28,958	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	442	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	500,382	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	166,749	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	476,061	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	464,903	361,121	54,700	126,796	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	366,056	139,050	0	48,823	0	76.01
76.02	03610	SLEEP LAB	54,664	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	84,458	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	632,668	174,643	70,896	61,320	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	206,627	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	85,075	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,667,004	4,557,264	393,398	1,560,198	2,255,053	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	398,350	0	0	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
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)	12,065,354	4,557,264	393,398	1,560,198	2,255,053	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

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

Worksheet B
Part I
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,753,138					11.00
13.00	01300	43,868	1,498,390				13.00
14.00	01400	0	0	1,257,170			14.00
15.00	01500	53,968	0	0	1,829,268		15.00
16.00	01600	129,109	199,700	0	0	3,096,115	16.00
17.00	01700	3,894	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	350,641	542,297	18,509	0	236,350	30.00
31.00	03100	51,595	79,818	28,398	0	33,039	31.00
40.00	04000	52,325	80,963	0	0	45,326	40.00
43.00	04300	13,872	21,466	0	0	11,832	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	81,469	126,016	0	0	209,283	50.00
51.00	05100	13,994	21,615	0	0	42,011	51.00
52.00	05200	60,357	93,381	0	0	60,726	52.00
53.00	05300	29,448	0	1,100	0	83,159	53.00
54.00	05400	164,338	0	0	0	615,991	54.00
58.00	05800	14,055	0	0	0	103,769	58.00
60.00	06000	105,198	0	2,290	0	481,262	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	40,278	0	0	0	46,687	65.00
66.00	06600	156,793	0	0	0	98,940	66.00
67.00	06700	8,336	0	0	0	13,923	67.00
68.00	06800	1,460	0	0	0	1,749	68.00
69.00	06900	11,134	0	0	0	25,510	69.00
70.00	07000	183	0	0	0	457	70.00
71.00	07100	0	0	1,018,865	0	222,119	71.00
72.00	07200	0	0	187,098	0	57,886	72.00
73.00	07300	0	0	0	1,829,268	197,785	73.00
75.00	07500	86,215	133,362	180	0	130,814	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	68,570	0	0	0	25,419	76.01
76.02	03610	0	0	0	0	8,494	76.02
76.97	07697	9,613	0	0	0	67,082	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	129,170	199,772	730	0	240,807	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	19,874	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	15,821	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		1,679,883	1,498,390	1,257,170	1,829,268	3,096,115	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	73,255	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,753,138	1,498,390	1,257,170	1,829,268	3,096,115	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

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

Worksheet B
Part I
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Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		17.00	19.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	204,710					17.00
19.00	01900		0				19.00
23.00	02300			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	179,291	0	0	10,583,700	0	30.00
31.00	03100	16,176	0	0	1,850,515	0	31.00
40.00	04000	0	0	0	1,448,981	0	40.00
43.00	04300	0	0	0	381,341	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	4,759,740	0	50.00
51.00	05100	0	0	0	665,831	0	51.00
52.00	05200	0	0	0	1,668,161	0	52.00
53.00	05300	0	0	0	1,105,499	0	53.00
54.00	05400	0	0	0	6,292,853	0	54.00
58.00	05800	0	0	0	651,138	0	58.00
60.00	06000	0	0	0	5,007,703	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	995,561	0	65.00
66.00	06600	0	0	0	4,815,452	0	66.00
67.00	06700	0	0	0	333,703	0	67.00
68.00	06800	0	0	0	113,766	0	68.00
69.00	06900	0	0	0	193,151	0	69.00
70.00	07000	0	0	0	3,028	0	70.00
71.00	07100	0	0	0	3,945,389	0	71.00
72.00	07200	0	0	0	1,146,211	0	72.00
73.00	07300	0	0	0	4,600,013	0	73.00
75.00	07500	2,311	0	0	3,408,151	0	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	0	0	0	2,260,280	0	76.01
76.02	03610	0	0	0	303,934	0	76.02
76.97	07697	0	0	0	533,165	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	6,932	0	0	4,303,643	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	1,136,630	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	475,626	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		204,710	0	0	62,983,165	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	2,226,211	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00			0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		204,710	0	0	65,209,376	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140110

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	10,583,700	30.00
31.00	03100 INTENSIVE CARE UNIT	1,850,515	31.00
40.00	04000 SUBPROVIDER - I/PF	1,448,981	40.00
43.00	04300 NURSERY	381,341	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	4,759,740	50.00
51.00	05100 RECOVERY ROOM	665,831	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,668,161	52.00
53.00	05300 ANESTHESIOLOGY	1,105,499	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,292,853	54.00
58.00	05800 MRI	651,138	58.00
60.00	06000 LABORATORY	5,007,703	60.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	995,561	65.00
66.00	06600 PHYSICAL THERAPY	4,815,452	66.00
67.00	06700 OCCUPATIONAL THERAPY	333,703	67.00
68.00	06800 SPEECH PATHOLOGY	113,766	68.00
69.00	06900 ELECTROCARDIOLOGY	193,151	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,028	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,945,389	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,146,211	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,600,013	73.00
75.00	07500 ASC (NON-DISTINCT PART)	3,408,151	75.00
76.00	03160 STRESS TESTING	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,260,280	76.01
76.02	03610 SLEEP LAB	303,934	76.02
76.97	07697 CARDIAC REHABILITATION	533,165	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	4,303,643	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY	1,136,630	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	475,626	116.00
117.00	06950 HOME MAKER	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	62,983,165	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2,226,211	192.00
194.00	07950 CARDINAL SLEEP	0	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	65,209,376	202.00

Provider CCN: 140110

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

Worksheet Non-CMS W
 Date/Time Prepared:
 2/26/2016 9:24 am

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
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	4	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	6	MEALS SERVED	10.00
11.00	CAFETERIA	7	FTES SERVED	11.00
13.00	NURSING ADMINISTRATION	8	HOURS SUPERVISED	13.00
14.00	CENTRAL SERVICES & SUPPLY	9	COSTED REQUIS.	14.00
15.00	PHARMACY	10	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	12	TIME SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS	13	ASSIGNED TIME	19.00
23.00	PARAMEDICAL PRGM-(SPECIFY)	14	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140110

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

Worksheet B
Part II
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	27,999	592	28,591	28,591 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,171,679	317,823	524,537	2,014,039	2,444 5.00
7.00 00700	OPERATION OF PLANT	0	1,769,167	52,686	1,821,853	820 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	23,660	0	23,660	35 8.00
9.00 00900	HOUSEKEEPING	0	42,049	2,394	44,443	754 9.00
10.00 01000	DIETARY	0	199,573	9,754	209,327	709 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	29,739	12,907	42,646	761 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	117,897	133,757	251,654	214 14.00
15.00 01500	PHARMACY	0	30,521	64,919	95,440	920 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	95,044	5,013	100,057	1,340 16.00
17.00 01700	SOCIAL SERVICE	0	17,632	48	17,680	81 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	555,005	163,368	718,373	3,811 30.00
31.00 03100	INTENSIVE CARE UNIT	0	48,355	7,895	56,250	770 31.00
40.00 04000	SUBPROVIDER - I PF	0	64,019	25,774	89,793	552 40.00
43.00 04300	NURSERY	0	0	0	0	176 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	174,046	394,318	568,364	883 50.00
51.00 05100	RECOVERY ROOM	0	18,666	3,024	21,690	314 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	767 52.00
53.00 05300	ANESTHESIOLOGY	0	0	10,279	10,279	1,495 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	169,581	701,270	870,851	1,872 54.00
58.00 05800	MRI	0	52,971	0	52,971	200 58.00
60.00 06000	LABORATORY	0	159,088	36,238	195,326	1,131 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	29,891	22,490	52,381	432 65.00
66.00 06600	PHYSICAL THERAPY	0	381,211	60,507	441,718	1,750 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	21,440	0	21,440	142 67.00
68.00 06800	SPEECH PATHOLOGY	0	12,057	7,402	19,459	38 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	95 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	1 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	208,578	93,781	302,359	1,131 75.00
76.00 03160	STRESS TESTING	0	0	0	0	0 76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	80,313	42,975	123,288	1,947 76.01
76.02 03610	SLEEP LAB	0	0	31,175	31,175	125 76.02
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	82 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	100,871	69,596	170,467	2,112 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	34,973	34,973	569 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	0	0	631	631	115 116.00
117.00 06950	HOMEMAKER	0	0	0	0	0 117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,171,679	4,747,196	2,512,303	8,431,178	28,588 118.00
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	602,629	602,629	3 192.00
194.00 07950	CARDINAL SLEEP	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	1,171,679	4,747,196	3,114,932	9,033,807	28,591 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 2/26/2016 9:24 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,016,483			5.00
7.00	00700	OPERATION OF PLANT	140,926	1,963,599		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,898	17,650	52,243	8.00
9.00	00900	HOUSEKEEPING	45,995	31,368	0	9.00
10.00	01000	DIETARY	55,297	148,879	0	10.00
11.00	01100	CAFETERIA	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	42,828	22,185	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,348	87,950	0	14.00
15.00	01500	PHARMACY	52,691	22,768	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,699	70,902	0	16.00
17.00	01700	SOCIAL SERVICE	4,935	13,153	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
23.00	02300	PARAMED ED PRGM - (SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	228,975	414,030	22,040	30.00
31.00	03100	INTENSIVE CARE UNIT	46,012	36,072	2,351	31.00
40.00	04000	SUBPROVIDER - IPF	31,709	47,757	436	40.00
43.00	04300	NURSERY	10,334	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	121,105	129,837	2,596	50.00
51.00	05100	RECOVERY ROOM	16,839	13,924	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,953	0	0	52.00
53.00	05300	ANESTHESIOLOGY	30,670	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,645	126,506	2,379	54.00
58.00	05800	MRI	12,660	39,515	0	58.00
60.00	06000	LABORATORY	125,141	118,678	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,935	22,298	0	65.00
66.00	06600	PHYSICAL THERAPY	112,084	284,380	5,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,080	15,994	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,547	8,994	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,840	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,629	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,869	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,565	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	77,700	155,597	7,264	75.00
76.00	03160	STRESS TESTING	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	61,179	59,913	0	76.01
76.02	03610	SLEEP LAB	9,136	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	14,116	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	105,739	75,249	9,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	34,534	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	14,219	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,949,906	1,963,599	52,243	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	66,577	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,016,483	1,963,599	52,243	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 2/26/2016 9:24 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	329,428					11.00
13.00	01300	8,243	118,083				13.00
14.00	01400	0	0	375,796			14.00
15.00	01500	10,141	0	0	183,417		15.00
16.00	01600	24,261	15,738	0	0	295,536	16.00
17.00	01700	732	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	65,888	42,737	5,533	0	22,559	30.00
31.00	03100	9,695	6,290	8,489	0	3,154	31.00
40.00	04000	9,832	6,380	0	0	4,326	40.00
43.00	04300	2,607	1,692	0	0	1,129	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	15,309	9,931	0	0	19,976	50.00
51.00	05100	2,630	1,703	0	0	4,010	51.00
52.00	05200	11,341	7,359	0	0	5,796	52.00
53.00	05300	5,534	0	329	0	7,937	53.00
54.00	05400	30,880	0	0	0	58,811	54.00
58.00	05800	2,641	0	0	0	9,905	58.00
60.00	06000	19,768	0	684	0	45,936	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	7,569	0	0	0	4,456	65.00
66.00	06600	29,463	0	0	0	9,444	66.00
67.00	06700	1,566	0	0	0	1,329	67.00
68.00	06800	274	0	0	0	167	68.00
69.00	06900	2,092	0	0	0	2,435	69.00
70.00	07000	34	0	0	0	44	70.00
71.00	07100	0	0	304,561	0	21,201	71.00
72.00	07200	0	0	55,928	0	5,525	72.00
73.00	07300	0	0	0	183,417	18,878	73.00
75.00	07500	16,200	10,510	54	0	12,486	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	12,885	0	0	0	2,426	76.01
76.02	03610	0	0	0	0	811	76.02
76.97	07697	1,806	0	0	0	6,403	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	24,272	15,743	218	0	22,985	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	1,897	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	1,510	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		315,663	118,083	375,796	183,417	295,536	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	13,765	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		329,428	118,083	375,796	183,417	295,536	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 2/26/2016 9:24 am		
Cost Center	Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		17.00	19.00	23.00	24.00	25.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	37,423				17.00
19.00	01900	0	0			19.00
23.00	02300	0		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	32,777			1,655,996	0 30.00
31.00	03100	2,957			178,620	0 31.00
40.00	04000	0			211,118	0 40.00
43.00	04300	0			15,938	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0			876,312	0 50.00
51.00	05100	0			62,001	0 51.00
52.00	05200	0			70,216	0 52.00
53.00	05300	0			56,244	0 53.00
54.00	05400	0			1,257,042	0 54.00
58.00	05800	0			120,422	0 58.00
60.00	06000	0			514,261	0 60.00
64.00	06400	0			0	0 64.00
65.00	06500	0			114,498	0 65.00
66.00	06600	0			902,805	0 66.00
67.00	06700	0			49,575	0 67.00
68.00	06800	0			32,055	0 68.00
69.00	06900	0			9,462	0 69.00
70.00	07000	0			153	0 70.00
71.00	07100	0			409,391	0 71.00
72.00	07200	0			89,322	0 72.00
73.00	07300	0			281,860	0 73.00
75.00	07500	422			593,683	0 75.00
76.00	03160	0			0	0 76.00
76.01	03550	0			265,473	0 76.01
76.02	03610	0			41,247	0 76.02
76.97	07697	0			22,407	0 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	1,267			432,284	0 91.00
92.00	09200					0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0			71,973	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
116.00	11600	0			16,475	0 116.00
117.00	06950	0			0	0 117.00
118.00		37,423	0	0	8,350,833	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0			0	0 190.00
192.00	19200	0			682,974	0 192.00
194.00	07950	0			0	0 194.00
200.00			0	0	0	0 200.00
201.00		0	0	0	0	0 201.00
202.00		37,423	0	0	9,033,807	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 2/26/2016 9:24 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
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
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
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 PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03160	STRESS TESTING	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01
76.02	03610	SLEEP LAB	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
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
117.00	06950	HOMEMAKER	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	CARDINAL SLEEP	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

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

Worksheet B-1

Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	188,201				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,070,694			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,110	584	29,160,672		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	12,600	517,087	2,493,935	-12,065,354	5.00
7.00 00700	OPERATION OF PLANT	70,138	51,938	836,889	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	938	0	35,562	0	8.00
9.00 00900	HOUSEKEEPING	1,667	2,360	769,711	0	9.00
10.00 01000	DIETARY	7,912	9,615	723,217	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,179	12,724	776,793	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,674	131,857	218,148	0	14.00
15.00 01500	PHARMACY	1,210	63,997	938,634	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,768	4,942	1,367,175	0	16.00
17.00 01700	SOCIAL SERVICE	699	47	82,856	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	22,003	161,048	3,871,881	0	30.00
31.00 03100	INTENSIVE CARE UNIT	1,917	7,783	785,418	0	31.00
40.00 04000	SUBPROVIDER - IPF	2,538	25,408	563,775	0	40.00
43.00 04300	NURSERY	0	0	179,909	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,900	388,718	901,452	0	50.00
51.00 05100	RECOVERY ROOM	740	2,981	319,981	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	782,634	0	52.00
53.00 05300	ANESTHESIOLOGY	0	10,133	1,525,315	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,723	691,311	1,910,507	0	54.00
58.00 05800	MRI	2,100	0	204,175	0	58.00
60.00 06000	LABORATORY	6,307	35,723	1,153,592	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,185	22,171	441,167	0	65.00
66.00 06600	PHYSICAL THERAPY	15,113	59,648	1,785,351	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	850	0	145,396	0	67.00
68.00 06800	SPEECH PATHOLOGY	478	7,297	38,718	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	96,879	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	1,478	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
75.00 07500	ASC (NON-DISTINCT PART)	8,269	92,449	1,154,495	0	75.00
76.00 03160	STRESS TESTING	0	0	0	0	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,184	42,365	1,986,965	0	76.01
76.02 03610	SLEEP LAB	0	30,732	127,995	0	76.02
76.97 07697	CARDIAC REHABILITATION	0	0	83,951	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3,999	68,608	2,155,058	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	34,476	581,018	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	622	117,623	0	116.00
117.00 06950	HOMEMAKER	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	188,201	2,476,624	29,157,653	-12,065,354	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	594,070	3,019	0	192.00
194.00 07950	CARDINAL SLEEP	0	0	0	0	194.00
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)	4,747,196	3,114,932	9,231,582	12,065,354	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25.224074	1.014407	0.316576		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			28,591	2,016,483	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000980	0.037944	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet B-1		
Date/Time Prepared: 2/26/2016 9:24 am								
Cost Center	Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	104,353				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	938	322,212			8.00	
9.00	00900	HOUSEKEEPING	1,667	0	101,748		9.00	
10.00	01000	DIETARY	7,912	0	7,912	209,243	10.00	
11.00	01100	CAFETERIA	0	0	0	162,671	11.00	
13.00	01300	NURSING ADMINISTRATION	1,179	0	1,179	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	4,674	0	4,674	0	14.00	
15.00	01500	PHARMACY	1,210	0	1,210	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	3,768	0	3,768	0	16.00	
17.00	01700	SOCIAL SERVICE	699	0	699	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,003	135,936	22,003	35,932	5,763	30.00
31.00	03100	INTENSIVE CARE UNIT	1,917	14,498	1,917	2,109	848	31.00
40.00	04000	SUBPROVIDER - I/PF	2,538	2,686	2,538	8,531	860	40.00
43.00	04300	NURSERY	0	0	0	0	228	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,900	16,010	6,900	0	1,339	50.00
51.00	05100	RECOVERY ROOM	740	0	740	0	230	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	992	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	484	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,723	14,674	6,723	0	2,701	54.00
58.00	05800	MRI	2,100	0	2,100	0	231	58.00
60.00	06000	LABORATORY	6,307	0	6,307	0	1,729	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,185	0	1,185	0	662	65.00
66.00	06600	PHYSICAL THERAPY	15,113	35,539	15,113	0	2,577	66.00
67.00	06700	OCCUPATIONAL THERAPY	850	0	850	0	137	67.00
68.00	06800	SPEECH PATHOLOGY	478	0	478	0	24	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	183	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	3	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	8,269	44,802	8,269	0	1,417	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,184	0	3,184	0	1,127	76.01
76.02	03610	SLEEP LAB	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	158	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,999	58,067	3,999	0	2,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	104,353	322,212	101,748	209,243	27,610	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	1,204	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
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)	4,557,264	393,398	1,560,198	2,255,053	1,753,138	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.671615	1.220929	15.333943	10.777197	60.843271	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,963,599	52,243	122,560	423,742	329,428	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	18.816891	0.162139	1.204545	2.025119	11.432915	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

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

Worksheet B-1

Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		NURSING ADMINISTRATIVE (HOURS SUPPORTED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	331,222					13.00
14.00	01400	0	125,725				14.00
15.00	01500	0	0	100			15.00
16.00	01600	44,144	0	0	236,413,196		16.00
17.00	01700	0	0	0	0	1,506	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	119,876	1,851	0	18,047,474	1,319	30.00
31.00	03100	17,644	2,840	0	2,522,842	119	31.00
40.00	04000	17,897	0	0	3,461,080	0	40.00
43.00	04300	4,745	0	0	903,455	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	27,856	0	0	15,980,652	0	50.00
51.00	05100	4,778	0	0	3,207,957	0	51.00
52.00	05200	20,642	0	0	4,636,964	0	52.00
53.00	05300	0	110	0	6,349,946	0	53.00
54.00	05400	0	0	0	47,033,085	0	54.00
58.00	05800	0	0	0	7,923,691	0	58.00
60.00	06000	0	229	0	36,748,778	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	3,564,972	0	65.00
66.00	06600	0	0	0	7,554,944	0	66.00
67.00	06700	0	0	0	1,063,111	0	67.00
68.00	06800	0	0	0	133,538	0	68.00
69.00	06900	0	0	0	1,947,953	0	69.00
70.00	07000	0	0	0	34,863	0	70.00
71.00	07100	0	101,893	0	16,960,845	0	71.00
72.00	07200	0	18,711	0	4,420,148	0	72.00
73.00	07300	0	0	100	15,102,722	0	73.00
75.00	07500	29,480	18	0	9,988,820	17	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	0	0	0	1,940,957	0	76.01
76.02	03610	0	0	0	648,590	0	76.02
76.97	07697	0	0	0	5,122,352	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	44,160	73	0	18,387,797	51	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	1,517,551	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	1,208,109	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		331,222	125,725	100	236,413,196	1,506	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		1,498,390	1,257,170	1,829,268	3,096,115	204,710	202.00
203.00		4.523824	9.999364	18,292.680000	0.013096	135.929615	203.00
204.00		118,083	375,796	183,417	295,536	37,423	204.00
205.00		0.356507	2.989032	1,834.170000	0.001250	24.849270	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

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

Worksheet B-1
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMED PRGM (ASSIGNED TIME)	
		19.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	23.00
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 - I/PF	0	40.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
76.00	03160	STRESS TESTING	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.01
76.02	03610	SLEEP LAB	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
117.00	06950	HOMEMAKER	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	CARDINAL SLEEP	0	194.00
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)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

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

Worksheet C
Part I
Date/Time Prepared:
2/26/2016 9:24 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,583,700		10,583,700	10,576	10,594,276	30.00
31.00	03100 INTENSIVE CARE UNIT	1,850,515		1,850,515	0	1,850,515	31.00
40.00	04000 SUBPROVIDER - IPF	1,448,981		1,448,981	0	1,448,981	40.00
43.00	04300 NURSERY	381,341		381,341	0	381,341	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,759,740		4,759,740	0	4,759,740	50.00
51.00	05100 RECOVERY ROOM	665,831		665,831	0	665,831	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,668,161		1,668,161	0	1,668,161	52.00
53.00	05300 ANESTHESIOLOGY	1,105,499		1,105,499	287,007	1,392,506	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,292,853		6,292,853	0	6,292,853	54.00
58.00	05800 MRI	651,138		651,138	0	651,138	58.00
60.00	06000 LABORATORY	5,007,703		5,007,703	0	5,007,703	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	995,561	0	995,561	398	995,959	65.00
66.00	06600 PHYSICAL THERAPY	4,815,452	0	4,815,452	33,084	4,848,536	66.00
67.00	06700 OCCUPATIONAL THERAPY	333,703	0	333,703	0	333,703	67.00
68.00	06800 SPEECH PATHOLOGY	113,766	0	113,766	0	113,766	68.00
69.00	06900 ELECTROCARDIOLOGY	193,151		193,151	0	193,151	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,028		3,028	0	3,028	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,945,389		3,945,389	0	3,945,389	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,146,211		1,146,211	0	1,146,211	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,600,013		4,600,013	0	4,600,013	73.00
75.00	07500 ASC (NON-DISTINCT PART)	3,408,151		3,408,151	0	3,408,151	75.00
76.00	03160 STRESS TESTING	0		0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,260,280		2,260,280	46,834	2,307,114	76.01
76.02	03610 SLEEP LAB	303,934		303,934	0	303,934	76.02
76.97	07697 CARDIAC REHABILITATION	533,165		533,165	0	533,165	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	4,303,643		4,303,643	514,779	4,818,422	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,604,663		1,604,663	0	1,604,663	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	1,136,630		1,136,630	0	1,136,630	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	475,626		475,626	0	475,626	116.00
117.00	06950 HOMEMAKER	0		0	0	0	117.00
200.00	Subtotal (see instructions)	64,587,828	0	64,587,828	892,678	65,480,506	200.00
201.00	Less Observation Beds	1,604,663		1,604,663	0	1,604,663	201.00
202.00	Total (see instructions)	62,983,165	0	62,983,165	892,678	63,875,843	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

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

Worksheet C
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,079,520		15,079,520		30.00
31.00	03100	INTENSIVE CARE UNIT	2,522,842		2,522,842		31.00
40.00	04000	SUBPROVIDER - IPF	3,461,080		3,461,080		40.00
43.00	04300	NURSERY	903,455		903,455		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,004,277	12,976,375	15,980,652	0.297844	50.00
51.00	05100	RECOVERY ROOM	311,567	2,896,390	3,207,957	0.207556	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,785,207	851,757	4,636,964	0.359753	52.00
53.00	05300	ANESTHESIOLOGY	1,582,988	4,766,958	6,349,946	0.174096	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,964,423	40,068,662	47,033,085	0.133796	54.00
58.00	05800	MRI	473,023	7,450,668	7,923,691	0.082176	58.00
60.00	06000	LABORATORY	9,808,900	26,939,878	36,748,778	0.136269	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,174,255	1,390,717	3,564,972	0.279262	65.00
66.00	06600	PHYSICAL THERAPY	446,501	7,108,443	7,554,944	0.637391	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,232	1,010,879	1,063,111	0.313893	67.00
68.00	06800	SPEECH PATHOLOGY	41,070	92,468	133,538	0.851937	68.00
69.00	06900	ELECTROCARDIOLOGY	681,345	1,266,608	1,947,953	0.099156	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,531	26,332	34,863	0.086854	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,268,660	10,692,185	16,960,845	0.232617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,031,925	3,388,223	4,420,148	0.259315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,138,557	7,964,165	15,102,722	0.304582	73.00
75.00	07500	ASC (NON-DISTINCT PART)	523,851	9,464,969	9,988,820	0.341197	75.00
76.00	03160	STRESS TESTING	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,889	1,935,068	1,940,957	1.164518	76.01
76.02	03610	SLEEP LAB	0	648,590	648,590	0.468607	76.02
76.97	07697	CARDIAC REHABILITATION	985,893	4,136,459	5,122,352	0.104086	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,259,597	14,128,200	18,387,797	0.234049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	518,185	2,449,769	2,967,954	0.540663	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,517,551	1,517,551		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	1,208,109	1,208,109		116.00
117.00	06950	HOMEMAKER	0	0	0		117.00
200.00		Subtotal (see instructions)	72,033,773	164,379,423	236,413,196		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	72,033,773	164,379,423	236,413,196		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140110

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

Worksheet C
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		PPS Inpatient Ratio	Title XVII I	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 - I PF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.297844			50.00
51.00	05100 RECOVERY ROOM	0.207556			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.359753			52.00
53.00	05300 ANESTHESIOLOGY	0.219294			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133796			54.00
58.00	05800 MRI	0.082176			58.00
60.00	06000 LABORATORY	0.136269			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.279374			65.00
66.00	06600 PHYSICAL THERAPY	0.641770			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313893			67.00
68.00	06800 SPEECH PATHOLOGY	0.851937			68.00
69.00	06900 ELECTROCARDIOLOGY	0.099156			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.086854			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.232617			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.259315			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304582			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.341197			75.00
76.00	03160 STRESS TESTING	0.000000			76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188648			76.01
76.02	03610 SLEEP LAB	0.468607			76.02
76.97	07697 CARDIAC REHABILITATION	0.104086			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.262045			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.540663			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
117.00	06950 HOMEMAKER				117.00
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: 140110

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

Worksheet C
Part I
Date/Time Prepared:
2/26/2016 9:24 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		10,583,700		10,576	10,594,276	30.00
31.00	03100 INTENSIVE CARE UNIT		1,850,515		0	1,850,515	31.00
40.00	04000 SUBPROVIDER - IPF		1,448,981		0	1,448,981	40.00
43.00	04300 NURSERY		381,341		0	381,341	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		4,759,740		0	4,759,740	50.00
51.00	05100 RECOVERY ROOM		665,831		0	665,831	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,668,161		0	1,668,161	52.00
53.00	05300 ANESTHESIOLOGY		1,105,499		287,007	1,392,506	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,292,853		0	6,292,853	54.00
58.00	05800 MRI		651,138		0	651,138	58.00
60.00	06000 LABORATORY		5,007,703		0	5,007,703	60.00
64.00	06400 INTRAVENOUS THERAPY		0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	995,561		398	995,959	65.00
66.00	06600 PHYSICAL THERAPY	0	4,815,452		33,084	4,848,536	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	333,703		0	333,703	67.00
68.00	06800 SPEECH PATHOLOGY	0	113,766		0	113,766	68.00
69.00	06900 ELECTROCARDIOLOGY		193,151		0	193,151	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		3,028		0	3,028	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		3,945,389		0	3,945,389	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,146,211		0	1,146,211	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		4,600,013		0	4,600,013	73.00
75.00	07500 ASC (NON-DISTINCT PART)		3,408,151		0	3,408,151	75.00
76.00	03160 STRESS TESTING		0		0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		2,260,280		46,834	2,307,114	76.01
76.02	03610 SLEEP LAB		303,934		0	303,934	76.02
76.97	07697 CARDIAC REHABILITATION		533,165		0	533,165	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY		4,303,643		514,779	4,818,422	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,604,663		0	1,604,663	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY		1,136,630		0	1,136,630	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE		0		0	0	113.00
116.00	11600 HOSPICE		475,626		0	475,626	116.00
117.00	06950 HOMEMAKER		0		0	0	117.00
200.00	Subtotal (see instructions)	0	64,587,828		892,678	65,480,506	200.00
201.00	Less Observation Beds		1,604,663		0	1,604,663	201.00
202.00	Total (see instructions)	0	62,983,165		892,678	63,875,843	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/26/2016 9:24 am
		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	15,079,520		15,079,520	30.00
31.00	03100	INTENSIVE CARE UNIT	2,522,842		2,522,842	31.00
40.00	04000	SUBPROVIDER - IPF	3,461,080		3,461,080	40.00
43.00	04300	NURSERY	903,455		903,455	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,004,277	12,976,375	15,980,652	0.297844 50.00
51.00	05100	RECOVERY ROOM	311,567	2,896,390	3,207,957	0.207556 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,785,207	851,757	4,636,964	0.359753 52.00
53.00	05300	ANESTHESIOLOGY	1,582,988	4,766,958	6,349,946	0.174096 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,964,423	40,068,662	47,033,085	0.133796 54.00
58.00	05800	MRI	473,023	7,450,668	7,923,691	0.082176 58.00
60.00	06000	LABORATORY	9,808,900	26,939,878	36,748,778	0.136269 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	2,174,255	1,390,717	3,564,972	0.279262 65.00
66.00	06600	PHYSICAL THERAPY	446,501	7,108,443	7,554,944	0.637391 66.00
67.00	06700	OCCUPATIONAL THERAPY	52,232	1,010,879	1,063,111	0.313893 67.00
68.00	06800	SPEECH PATHOLOGY	41,070	92,468	133,538	0.851937 68.00
69.00	06900	ELECTROCARDIOLOGY	681,345	1,266,608	1,947,953	0.099156 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,531	26,332	34,863	0.086854 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,268,660	10,692,185	16,960,845	0.232617 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,031,925	3,388,223	4,420,148	0.259315 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,138,557	7,964,165	15,102,722	0.304582 73.00
75.00	07500	ASC (NON-DISTINCT PART)	523,851	9,464,969	9,988,820	0.341197 75.00
76.00	03160	STRESS TESTING	0	0	0	0.000000 76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,889	1,935,068	1,940,957	1.164518 76.01
76.02	03610	SLEEP LAB	0	648,590	648,590	0.468607 76.02
76.97	07697	CARDIAC REHABILITATION	985,893	4,136,459	5,122,352	0.104086 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,259,597	14,128,200	18,387,797	0.234049 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	518,185	2,449,769	2,967,954	0.540663 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,517,551	1,517,551	
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	1,208,109	1,208,109	116.00
117.00	06950	HOMEMAKER	0	0	0	117.00
200.00		Subtotal (see instructions)	72,033,773	164,379,423	236,413,196	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	72,033,773	164,379,423	236,413,196	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/26/2016 9:24 am
		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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
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
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
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 PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03160 STRESS TESTING	0.000000		76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.01
76.02	03610 SLEEP LAB	0.000000		76.02
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
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
117.00	06950 HOMEMAKER			117.00
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: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part I Date/Time Prepared: 2/26/2016 9:24 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,655,996	0	1,655,996	11,369	145.66	30.00
31.00	INTENSIVE CARE UNIT	178,620		178,620	963	185.48	31.00
40.00	SUBPROVIDER - IPF	211,118	0	211,118	1,948	108.38	40.00
43.00	NURSERY	15,938		15,938	1,023	15.58	43.00
200.00	Total (Lines 30-199)	2,061,672		2,061,672	15,303		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	3,479	506,751				
31.00	INTENSIVE CARE UNIT	607	112,586				
40.00	SUBPROVIDER - IPF	1,212	131,357				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	5,298	750,694				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part II Date/Time Prepared: 2/26/2016 9:24 am
		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	876,312	15,980,652	0.054836	1,335,106	73,212	50.00
51.00	05100 RECOVERY ROOM	62,001	3,207,957	0.019327	135,888	2,626	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	70,216	4,636,964	0.015143	10,512	159	52.00
53.00	05300 ANESTHESIOLOGY	56,244	6,349,946	0.008857	598,559	5,301	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,257,042	47,033,085	0.026727	3,577,639	95,620	54.00
58.00	05800 MRI	120,422	7,923,691	0.015198	233,451	3,548	58.00
60.00	06000 LABORATORY	514,261	36,748,778	0.013994	4,612,994	64,554	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	114,498	3,564,972	0.032118	1,372,637	44,086	65.00
66.00	06600 PHYSICAL THERAPY	902,805	7,554,944	0.119499	315,571	37,710	66.00
67.00	06700 OCCUPATIONAL THERAPY	49,575	1,063,111	0.046632	30,309	1,413	67.00
68.00	06800 SPEECH PATHOLOGY	32,055	133,538	0.240044	29,840	7,163	68.00
69.00	06900 ELECTROCARDIOLOGY	9,462	1,947,953	0.004857	387,011	1,880	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	153	34,863	0.004389	4,271	19	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	409,391	16,960,845	0.024137	3,281,730	79,211	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	89,322	4,420,148	0.020208	663,973	13,418	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	281,860	15,102,722	0.018663	3,094,846	57,759	73.00
75.00	07500 ASC (NON-DISTINCT PART)	593,683	9,988,820	0.059435	322,133	19,146	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	265,473	1,940,957	0.136774	3,212	439	76.01
76.02	03610 SLEEP LAB	41,247	648,590	0.063595	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	22,407	5,122,352	0.004374	645,523	2,824	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	432,284	18,387,797	0.023509	1,995,053	46,902	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	250,825	2,967,954	0.084511	272,709	23,047	92.00
200.00	Total (lines 50-199)	6,451,538	211,720,639		22,922,967	580,037	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part III Date/Time Prepared: 2/26/2016 9:24 am
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Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	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	11,369	0.00	3,479	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	963	0.00	607	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,948	0.00	1,212	0	0	40.00
43.00	04300	NURSERY	1,023	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	15,303		5,298	0	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				
31.00	03100	INTENSIVE CARE UNIT	0	0				
40.00	04000	SUBPROVIDER - IPF	0	0				
43.00	04300	NURSERY	0	0				
200.00		Total (lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140110

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00	
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	0	0	0	0	0 54.00	
58.00	05800	MRI	0	0	0	0	0 58.00	
60.00	06000	LABORATORY	0	0	0	0	0 60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00	
76.00	03160	STRESS TESTING	0	0	0	0	0 76.00	
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.01	
76.02	03610	SLEEP LAB	0	0	0	0	0 76.02	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97	
OUTPATIENT SERVICE COST CENTERS								
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)	0	0	0	0	0 200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 9:24 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	15,980,652	0.000000	0.000000	1,335,106	50.00
51.00	05100 RECOVERY ROOM	0	3,207,957	0.000000	0.000000	135,888	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4,636,964	0.000000	0.000000	10,512	52.00
53.00	05300 ANESTHESIOLOGY	0	6,349,946	0.000000	0.000000	598,559	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	47,033,085	0.000000	0.000000	3,577,639	54.00
58.00	05800 MRI	0	7,923,691	0.000000	0.000000	233,451	58.00
60.00	06000 LABORATORY	0	36,748,778	0.000000	0.000000	4,612,994	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,564,972	0.000000	0.000000	1,372,637	65.00
66.00	06600 PHYSICAL THERAPY	0	7,554,944	0.000000	0.000000	315,571	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,063,111	0.000000	0.000000	30,309	67.00
68.00	06800 SPEECH PATHOLOGY	0	133,538	0.000000	0.000000	29,840	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,947,953	0.000000	0.000000	387,011	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	34,863	0.000000	0.000000	4,271	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,960,845	0.000000	0.000000	3,281,730	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,420,148	0.000000	0.000000	663,973	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	15,102,722	0.000000	0.000000	3,094,846	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	9,988,820	0.000000	0.000000	322,133	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0.000000	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,940,957	0.000000	0.000000	3,212	76.01
76.02	03610 SLEEP LAB	0	648,590	0.000000	0.000000	0	76.02
76.97	07697 CARDIAC REHABILITATION	0	5,122,352	0.000000	0.000000	645,523	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	18,387,797	0.000000	0.000000	1,995,053	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,967,954	0.000000	0.000000	272,709	92.00
200.00	Total (lines 50-199)	0	211,720,639			22,922,967	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 9:24 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	4,210,610	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	839,647	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,536	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,499,186	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	13,997,205	0	0	0	54.00
58.00	05800 MRI	0	2,182,686	0	0	0	58.00
60.00	06000 LABORATORY	0	3,784,847	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	558,154	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	384,363	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	484,487	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	7,461	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,707,347	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,468,590	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,935,218	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	3,792,308	0	0	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	495,993	0	0	0	76.01
76.02	03610 SLEEP LAB	0	193,305	0	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0	1,914,299	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	3,497,462	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	791,180	0	0	0	92.00
200.00	Total (lines 50-199)	0	47,747,884	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 9:24 am
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
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
58.00	05800 MRI	0	0			58.00
60.00	06000 LABORATORY	0	0			60.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
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 PATIENT	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
75.00	07500 ASC (NON-DISTINCT PART)	0	0			75.00
76.00	03160 STRESS TESTING	0	0			76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0			76.01
76.02	03610 SLEEP LAB	0	0			76.02
76.97	07697 CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS						
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: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/26/2016 9:24 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.297844	4,210,610	0	84	1,254,105 50.00
51.00	05100 RECOVERY ROOM	0.207556	839,647	0	0	174,274 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.359753	3,536	0	0	1,272 52.00
53.00	05300 ANESTHESIOLOGY	0.174096	1,499,186	0	0	261,002 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133796	13,997,205	13,850	34,199	1,872,770 54.00
58.00	05800 MRI	0.082176	2,182,686	0	0	179,364 58.00
60.00	06000 LABORATORY	0.136269	3,784,847	2,220	0	515,757 60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.279262	558,154	2	0	155,871 65.00
66.00	06600 PHYSICAL THERAPY	0.637391	384,363	0	0	244,990 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313893	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.851937	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.099156	484,487	0	0	48,040 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.086854	7,461	0	0	648 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.232617	3,707,347	0	673	862,392 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.259315	1,468,590	0	0	380,827 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304582	3,935,218	0	23,474	1,198,597 73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.341197	3,792,308	0	0	1,293,924 75.00
76.00	03160 STRESS TESTING	0.000000	0	0	0	0 76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.164518	495,993	0	0	577,593 76.01
76.02	03610 SLEEP LAB	0.468607	193,305	0	0	90,584 76.02
76.97	07697 CARDIAC REHABILITATION	0.104086	1,914,299	0	0	199,252 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.234049	3,497,462	0	0	818,577 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.540663	791,180	0	0	427,762 92.00
200.00	Subtotal (see instructions)		47,747,884	16,072	58,430	10,557,601 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		47,747,884	16,072	58,430	10,557,601 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/26/2016 9:24 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	25	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,853	4,576	54.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	303	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	1	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 PATIENT	0	157	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,150	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03160 STRESS TESTING	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.01
76.02	03610 SLEEP LAB	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
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)	2,157	11,908	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,157	11,908	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140110 Component CCN: 14S110		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part II Date/Time Prepared: 2/26/2016 9:24 am		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	876,312	15,980,652	0.054836	587	32	50.00
51.00	05100	RECOVERY ROOM	62,001	3,207,957	0.019327	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,216	4,636,964	0.015143	0	0	52.00
53.00	05300	ANESTHESIOLOGY	56,244	6,349,946	0.008857	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,257,042	47,033,085	0.026727	87,914	2,350	54.00
58.00	05800	MRI	120,422	7,923,691	0.015198	2,940	45	58.00
60.00	06000	LABORATORY	514,261	36,748,778	0.013994	335,313	4,692	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	114,498	3,564,972	0.032118	48,181	1,547	65.00
66.00	06600	PHYSICAL THERAPY	902,805	7,554,944	0.119499	6,003	717	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,575	1,063,111	0.046632	2,418	113	67.00
68.00	06800	SPEECH PATHOLOGY	32,055	133,538	0.240044	1,666	400	68.00
69.00	06900	ELECTROCARDIOLOGY	9,462	1,947,953	0.004857	26,104	127	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	153	34,863	0.004389	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	409,391	16,960,845	0.024137	17,888	432	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	89,322	4,420,148	0.020208	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,860	15,102,722	0.018663	361,513	6,747	73.00
75.00	07500	ASC (NON-DISTINCT PART)	593,683	9,988,820	0.059435	0	0	75.00
76.00	03160	STRESS TESTING	0	0	0.000000	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	265,473	1,940,957	0.136774	1,360	186	76.01
76.02	03610	SLEEP LAB	41,247	648,590	0.063595	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	22,407	5,122,352	0.004374	2,559	11	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	432,284	18,387,797	0.023509	220,769	5,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,967,954	0.000000	25,575	0	92.00
200.00		Total (Lines 50-199)	6,200,713	211,720,639		1,140,790	22,589	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140110
Component CCN: 14S110

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

Worksheet D
Part IV
Date/Time Prepared:
2/26/2016 9:24 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
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	0	0	0	0	0	54.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03160 STRESS TESTING	0	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03610 SLEEP LAB	0	0	0	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
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)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110 Component CCN: 14S110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 9:24 am
Title XVIIII		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	0	15,980,652	0.000000	0.000000	587	50.00
51.00	05100 RECOVERY ROOM	0	3,207,957	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4,636,964	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	6,349,946	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	47,033,085	0.000000	0.000000	87,914	54.00
58.00	05800 MRI	0	7,923,691	0.000000	0.000000	2,940	58.00
60.00	06000 LABORATORY	0	36,748,778	0.000000	0.000000	335,313	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	3,564,972	0.000000	0.000000	48,181	65.00
66.00	06600 PHYSICAL THERAPY	0	7,554,944	0.000000	0.000000	6,003	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,063,111	0.000000	0.000000	2,418	67.00
68.00	06800 SPEECH PATHOLOGY	0	133,538	0.000000	0.000000	1,666	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,947,953	0.000000	0.000000	26,104	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	34,863	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,960,845	0.000000	0.000000	17,888	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,420,148	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	15,102,722	0.000000	0.000000	361,513	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	9,988,820	0.000000	0.000000	0	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0.000000	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,940,957	0.000000	0.000000	1,360	76.01
76.02	03610 SLEEP LAB	0	648,590	0.000000	0.000000	0	76.02
76.97	07697 CARDIAC REHABILITATION	0	5,122,352	0.000000	0.000000	2,559	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	18,387,797	0.000000	0.000000	220,769	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,967,954	0.000000	0.000000	25,575	92.00
200.00	Total (Lines 50-199)	0	211,720,639			1,140,790	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110 Component CCN: 14S110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 9:24 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
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	0	0	0	0	0	54.00
58.00 05800 MRI	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03160 STRESS TESTING	0	0	0	0	0	76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02 03610 SLEEP LAB	0	0	0	0	0	76.02
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
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)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/26/2016 9:24 am
	Component CCN: 14S110	Title XVII	Subprovider - IPF 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
51.00 05100 RECOVERY ROOM	0	0	51.00
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
58.00 05800 MRI	0	0	58.00
60.00 06000 LABORATORY	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
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 PATIENT	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
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03160 STRESS TESTING	0	0	76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.01
76.02 03610 SLEEP LAB	0	0	76.02
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 9:24 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,369	1.00
2.00	Total inpatient days (including private room days, excluding swing-bed and newborn days)		11,369	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)		9,647	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)		3,479	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)		10,594,276	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)		10,594,276	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)		10,594,276	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)		931.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,241,941	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)		3,241,941	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 9:24 am	
Cost Center Description			Title XVIII		Hospital	PPS
	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	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,850,515	963	1,921.61	607	1,166,417
44.00	CORONARY CARE UNIT					43.00
45.00	BURN INTENSIVE CARE UNIT					44.00
46.00	SURGICAL INTENSIVE CARE UNIT					45.00
47.00	OTHER SPECIAL CARE (SPECIFY)					46.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				5,076,404	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				9,484,762	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)				619,337	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				580,037	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,199,374	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				8,285,388	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)				1,722	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				931.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,604,663	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/26/2016 9:24 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,655,996	10,594,276	0.156310	1,604,663	250,825	90.00
91.00	Nursing School cost	0	10,594,276	0.000000	1,604,663	0	91.00
92.00	Allied health cost	0	10,594,276	0.000000	1,604,663	0	92.00
93.00	All other Medical Education	0	10,594,276	0.000000	1,604,663	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1
		Component CCN: 14S110		Date/Time Prepared: 2/26/2016 9:24 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,948	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,948	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)		1,948	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)		1,212	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)		1,448,981	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)		1,448,981	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,448,981	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		743.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		901,522	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)		901,522	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
		Component CCN: 14S110				Date/Time Prepared: 2/26/2016 9:24 am	
		Title XVIII		Subprovider - I/PF		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	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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)					267,785		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,169,307		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)					131,357		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					22,589		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					153,946		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					1,015,361		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: 140110 Component CCN: 14S110		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/26/2016 9:24 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	211,118	1,448,981	0.145701	0	0	90.00
91.00	Nursing School cost	0	1,448,981	0.000000	0	0	91.00
92.00	Allied health cost	0	1,448,981	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,448,981	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 2/26/2016 9:24 am	
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		3,435,854	30.00
31.00	03100	INTENSIVE CARE UNIT		1,530,208	31.00
40.00	04000	SUBPROVIDER - IPF		917,025	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.297844	1,335,106	50.00
51.00	05100	RECOVERY ROOM	0.207556	135,888	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.359753	10,512	52.00
53.00	05300	ANESTHESIOLOGY	0.219294	598,559	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133796	3,577,639	54.00
58.00	05800	MRI	0.082176	233,451	58.00
60.00	06000	LABORATORY	0.136269	4,612,994	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.279374	1,372,637	65.00
66.00	06600	PHYSICAL THERAPY	0.641770	315,571	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.313893	30,309	67.00
68.00	06800	SPEECH PATHOLOGY	0.851937	29,840	68.00
69.00	06900	ELECTROCARDIOLOGY	0.099156	387,011	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.086854	4,271	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.232617	3,281,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.259315	663,973	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.304582	3,094,846	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.341197	322,133	75.00
76.00	03160	STRESS TESTING	0.000000	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188648	3,212	76.01
76.02	03610	SLEEP LAB	0.468607	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.104086	645,523	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.262045	1,995,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.540663	272,709	92.00
200.00		Total (sum of lines 50-94 and 96-98)		22,922,967	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)		22,922,967	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140110 Component CCN: 14S110	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 2/26/2016 9:24 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		2,154,520	40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.297844	587	50.00
51.00	05100 RECOVERY ROOM	0.207556	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.359753	0	52.00
53.00	05300 ANESTHESIOLOGY	0.219294	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133796	87,914	54.00
58.00	05800 MRI	0.082176	2,940	58.00
60.00	06000 LABORATORY	0.136269	335,313	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.279374	48,181	65.00
66.00	06600 PHYSICAL THERAPY	0.641770	6,003	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.313893	2,418	67.00
68.00	06800 SPEECH PATHOLOGY	0.851937	1,666	68.00
69.00	06900 ELECTROCARDIOLOGY	0.099156	26,104	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.086854	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.232617	17,888	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.259315	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.304582	361,513	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.341197	0	75.00
76.00	03160 STRESS TESTING	0.000000	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1.188648	1,360	76.01
76.02	03610 SLEEP LAB	0.468607	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.104086	2,559	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.262045	220,769	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.540663	25,575	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,140,790	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)		1,140,790	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140110

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

Worksheet E
Part A
Date/Time Prepared:
2/26/2016 9:24 am

		Title XVIII		Hospital		PPS
		0	before 1/1	on/after 1/1	1.01	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)		8,263,470			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)		91,691			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		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		82.28			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)		0.00			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)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			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.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			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		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			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)		0.00			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)		0			29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 9:24 am	
		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)		1.00	1.01	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.10		30.00
31.00	Percentage of Medicaid patient days (see instructions)		40.60		31.00
32.00	Sum of lines 30 and 31		43.70		32.00
33.00	Allowable disproportionate share percentage (see instructions)		25.27		33.00
34.00	Disproportionate share adjustment (see instructions)		522,045		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		0.000068933 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		527,176 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		527,176 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		527,176		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)		9,404,382		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		9,404,382		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		669,821		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).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		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).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,074,203		59.00
60.00	Primary payer payments		-8,706		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,082,909		61.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 9:24 am
		Title XVIII	Hospital	PPS

		0	Prior to October 1 1.00	1.01	On/After October 1 2.00	
62.00	Deductibles billed to program beneficiaries		1,069,320			62.00
63.00	Coinurance billed to program beneficiaries		2,835			63.00
64.00	Allowable bad debts (see instructions)		252,305			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		163,998			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		240,896			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,174,752			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)		18,506			70.93
70.94	HRR adjustment amount (see instructions)		-154,527			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)	2015	528,896			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		104,671			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,462,956			71.00
71.01	Sequestration adjustment (see instructions)		189,259			71.01
72.00	Interim payments		9,115,581			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)		158,116			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		222,162			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: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 9:24 am
		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: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet DSH Date/Time Prepared: 2/26/2016 9:24 am
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		Original mcrx Values	Adjusted mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
Title XVII Hospital PPS							
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)	3.10	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	40.60	0.00			40.60	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	43.70	0.00			40.60	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)	82.28	0.00			82.28	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	25.27	0.00			22.71	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	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")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	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)	3,918	0			3,918	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	355	0			355	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	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)	389	0			389	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	142	0			142	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	4,804	0			4,804	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	11,633	0			11,633	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	199	0			199	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	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)	11,832	0			11,832	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	40.60	0.00			40.60	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet DSH Date/Time Prepared: 2/26/2016 9:24 am	
		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	True	25.27		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		25.27		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.		25.27		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-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet DSH Date/Time Prepared: 2/26/2016 9:24 am
		Title XVII	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	22.71	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	22.71	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.	22.71	31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140110

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2016 9:24 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,263,470	0	0	8,263,470	8,263,470	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	91,691	0	0	91,691	91,691	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2527	0.2527	0.2527	0.2527		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	522,045	0	0	522,045	522,045	11.00
11.01	Uncompensated care payments	36.00	527,176	0	0	527,176	527,176	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,404,382	0	0	9,404,382	9,404,382	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,404,382	0	0	9,404,382	9,404,382	15.00
16.00	Payment for inpatient program capital	50.00	669,821	0	0	669,821	669,821	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140110

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2016 9:24 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	10,074,203	10,074,203	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	660,739	0	0	660,739	660,739	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,082	0	0	9,082	9,082	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	0.0000	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	669,821	0	0	669,821	669,821	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.052500		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				528,896	528,896	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2016 9:24 am	
			Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00						1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	8,263,470		8,263,470	8,263,470	8,263,470	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	91,691	0	91,691	91,691	91,691	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000			5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000			7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2527	0.2527	0.2527			10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	522,045	0	522,045	522,045	522,045	11.00
11.01	Uncompensated care payments	36.00	527,176	0	527,176	527,176	527,176	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,404,382	0	9,404,382	9,404,382	9,404,382	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,404,382	0	9,404,382	9,404,382	9,404,382	15.00
16.00	Payment for inpatient program capital	50.00	669,821	0	669,821	669,821	669,821	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	10,074,203	10,074,203	10,074,203	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 140110		Period: From 10/01/2014 To 09/30/2015		Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2016 9:24 am	
			Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	660,739	0	660,739	660,739	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	9,082	0	9,082	9,082	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	669,821	0	669,821	669,821	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00		70.96	0	0		0	27.00	
28.00	Low volume adjustment prior to October 1	70.97	528,896		528,896	528,896	28.00	
30.00	HVBP payment adjustment (see instructions)	70.93	18,506	0	18,506	18,506	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-154,527	0	-154,527	-154,527	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	104,671	104,671	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/26/2016 9:24 am
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			14,065 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			10,557,601 2.00
3.00	PPS payments			7,804,334 3.00
4.00	Outlier payment (see instructions)			274,357 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)			14,065 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			74,502 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)			74,502 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)			74,502 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			60,437 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)			14,065 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)			8,078,691 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			3,111 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,722,112 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)			6,367,533 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)			6,367,533 30.00
31.00	Primary payer payments			843 31.00
32.00	Subtotal (line 30 minus line 31)			6,366,690 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)			267,818 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			174,082 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			239,697 36.00
37.00	Subtotal (see instructions)			6,540,772 37.00
38.00	MSP-LCC reconciliation amount from PS&R			1 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)			6,540,771 40.00
40.01	Sequestration adjustment (see instructions)			130,815 40.01
41.00	Interim payments			6,437,843 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-27,887 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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140110

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

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,891,718		6,244,868	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	09/30/2015	223,863	09/30/2015	192,975	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)		223,863		192,975	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)		9,115,581		6,437,843	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		158,116		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		27,887	6.02
7.00	Total Medicare program liability (see instructions)		9,273,697		6,409,956	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: 140110
Component CCN: 14S110

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

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2016 9:24 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		898,008		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		898,008		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		11		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		898,019		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140110

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

Worksheet E-1
Part II
Date/Time Prepared:
2/26/2016 9:24 am

		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			3,330 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			4,086 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			500 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			10,610 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			236,413,196 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			5,509,992 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)			539,010 8.00
9.00	Sequestration adjustment amount (see instructions)			10,780 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			528,230 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSPS & 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)			528,230 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140110 Component CCN: 14S110	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part II Date/Time Prepared: 2/26/2016 9:24 am
		Title XVIIII	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)			1,054,922 1.00
2.00	Net IPF PPS Outlier Payments			6,931 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)			5.336986 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)			1,061,853 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)			1,061,853 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,061,853 18.00
19.00	Deductibles			143,932 19.00
20.00	Subtotal (line 18 minus line 19)			917,921 20.00
21.00	Coinsurance			1,575 21.00
22.00	Subtotal (line 20 minus line 21)			916,346 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 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)			916,346 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)			0 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)			916,346 31.00
31.01	Sequestration adjustment (see instructions)			18,327 31.01
32.00	Interim payments			898,008 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)			11 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			6,931 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

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

Provider CCN: 140110

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

Worksheet G

Date/Time Prepared:
2/26/2016 9:24 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	11,179,705	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	43,510,728	0	0	0	4.00
5.00	Other receivable	2,436,922	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-36,649,833	0	0	0	6.00
7.00	Inventory	1,307,134	0	0	0	7.00
8.00	Prepaid expenses	338,557	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-6,574,035	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15,549,178	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,131,111	0	0	0	12.00
13.00	Land improvements	2,862,859	0	0	0	13.00
14.00	Accumulated depreciation	-2,558,606	0	0	0	14.00
15.00	Buildings	74,185,621	0	0	0	15.00
16.00	Accumulated depreciation	-57,247,623	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	38,039,462	0	0	0	19.00
20.00	Accumulated depreciation	-31,196,470	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	7,827,958	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	35,044,312	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,982,658	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,982,658	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	53,576,148	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,281,102	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,066,174	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	540,259	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,887,535	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,887,535	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	45,688,613				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)	45,688,613	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	53,576,148	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140110

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

Worksheet G-1

Date/Time Prepared:
2/26/2016 9:24 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		42,115,455			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,573,158				2.00
3.00	Total (sum of line 1 and line 2)		45,688,613			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		45,688,613			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		45,688,613			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	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140110

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	16,501,160		16,501,160	1.00
2.00	SUBPROVIDER - IPF	3,461,080		3,461,080	2.00
3.00	SUBPROVIDER - IRF				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				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)	19,962,240		19,962,240	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,522,842		2,522,842	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)	2,522,842		2,522,842	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	22,485,082		22,485,082	17.00
18.00	Ancillary services	45,289,094	144,427,204	189,716,298	18.00
19.00	Outpatient services	4,259,597	16,577,969	20,837,566	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,517,551	1,517,551	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	1	1,208,108	1,208,109	26.00
27.00	OTHER PATIENT INCOME	3,505,688	10,214,040	13,719,728	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	75,539,462	173,944,872	249,484,334	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		73,050,753		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		73,050,753		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140110

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

Worksheet G-3

Date/Time Prepared:
2/26/2016 9:24 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	249,484,334	1.00
2.00	Less contractual allowances and discounts on patients' accounts	177,757,613	2.00
3.00	Net patient revenues (line 1 minus line 2)	71,726,721	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	73,050,753	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,324,032	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,766,256	6.00
7.00	Income from investments	233,827	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	3,082	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	427,198	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	4,382	17.00
18.00	Revenue from sale of medical records and abstracts	-183	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	981,404	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER RENTAL INCOME	21,985	24.00
24.01	OTHER INCOME	476,572	24.01
25.00	Total other income (sum of lines 6-24)	4,914,523	25.00
26.00	Total (line 5 plus line 25)	3,590,491	26.00
27.00	LOSS ON SALE OF ASSETS	17,333	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	17,333	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,573,158	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140110

Period: From 10/01/2014

Worksheet H

HHA CCN: 147048

To 09/30/2015

Date/Time Prepared: 2/26/2016 9:24 am

Home Health Agency I

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	97,932	0	7,224	16,793	3,678	125,627	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	232,615	0	22,315	2,229	20,871	278,030	6.00
7.00	Physical Therapy	206,077	0	15,635	1,224	4,754	227,690	7.00
8.00	Occupational Therapy	5,457	0	0	0	0	5,457	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	21,756	0	2,170	0	0	23,926	10.00
11.00	Home Health Aide	17,181	0	3,625	0	539	21,345	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	581,018	0	50,969	20,246	29,842	682,075	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	9,145	134,772	0	134,772			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	278,030	0	278,030			6.00
7.00	Physical Therapy	0	227,690	0	227,690			7.00
8.00	Occupational Therapy	0	5,457	0	5,457			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	23,926	0	23,926			10.00
11.00	Home Health Aide	0	21,345	0	21,345			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	9,145	691,220	0	691,220			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: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet H-1 Part I Date/Time Prepared: 2/26/2016 9:24 am			
		HHA CCN: 147048	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				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	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	134,772	0	0	0	134,772	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	278,030	0	0	0	278,030	6.00
7.00	Physical Therapy	227,690	0	0	0	227,690	7.00
8.00	Occupational Therapy	5,457	0	0	0	5,457	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	23,926	0	0	0	23,926	10.00
11.00	Home Health Aide	21,345	0	0	0	21,345	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	691,220	0	0	0	691,220	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	134,772					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	67,338	345,368				6.00
7.00	Physical Therapy	55,147	282,837				7.00
8.00	Occupational Therapy	1,322	6,779				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	5,795	29,721				10.00
11.00	Home Health Aide	5,170	26,515				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		691,220				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140110

Period:

Worksheet H-1

HHA CCN: 147048

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

Part II
Date/Time Prepared:
2/26/2016 9:24 am

Home Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & 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	-134,772	556,448
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	278,030
7.00	Physical Therapy	0	0	0	0	0	227,690
8.00	Occupational Therapy	0	0	0	0	0	5,457
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	23,926
11.00	Home Health Aide	0	0	0	0	0	21,345
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-134,772	556,448
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		134,772
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.242201

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140110

Period: From 10/01/2014

Worksheet H-2

HHA CCN: 147048

To 09/30/2015

Part I
Date/Time Prepared:
2/26/2016 9:24 am

Home Health
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
1.00 Administrative and General	0	0	34,973	31,003	65,976	14,979	1.00	
2.00 Skilled Nursing Care	345,368	0	0	73,640	419,008	95,127	2.00	
3.00 Physical Therapy	282,837	0	0	65,239	348,076	79,024	3.00	
4.00 Occupational Therapy	6,779	0	0	1,728	8,507	1,931	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	29,721	0	0	6,887	36,608	8,311	6.00	
7.00 Home Health Aide	26,515	0	0	5,439	31,954	7,255	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)	691,220	0	34,973	183,936	910,129	206,627	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.00	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	0	0	0	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140110

Period:

Worksheet H-2

HHA CCN: 147048

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

Part I
Date/Time Prepared:
2/26/2016 9:24 am

Home Health
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PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED PRGM	
		14.00	15.00	16.00	17.00	19.00	23.00	
1.00	Administrative and General	0	0	19,874	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	0	19,874	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
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	100,829	0	100,829				1.00
2.00	Skilled Nursing Care	514,135	0	514,135	50,047	564,182		2.00
3.00	Physical Therapy	427,100	0	427,100	41,576	468,676		3.00
4.00	Occupational Therapy	10,438	0	10,438	1,016	11,454		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	44,919	0	44,919	4,373	49,292		6.00
7.00	Home Health Aide	39,209	0	39,209	3,817	43,026		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	1,136,630	0	1,136,630	100,829	1,136,630		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.				0.097344			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: 140110 HHA CCN: 147048	Period: From 10/01/2014 To 09/30/2015	Worksheet H-2 Part II Date/Time Prepared: 2/26/2016 9:24 am
			Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	34,476	97,932	0	65,976	0	1.00
2.00 Skilled Nursing Care	0	0	232,615	0	419,008	0	2.00
3.00 Physical Therapy	0	0	206,077	0	348,076	0	3.00
4.00 Occupational Therapy	0	0	5,457	0	8,507	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	21,756	0	36,608	0	6.00
7.00 Home Health Aide	0	0	17,181	0	31,954	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	34,476	581,018		910,129	0	20.00
21.00 Total cost to be allocated	0	34,973	183,936		206,627	0	21.00
22.00 Unit cost multiplier	0.000000	1.014416	0.316575		0.227030	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATIVE (HOURS SUPPLEMENTED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00 Total cost to be allocated	0	0	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140110 HHA CCN: 147048	Period: From 10/01/2014 To 09/30/2015	Worksheet H-2 Part II Date/Time Prepared: 2/26/2016 9:24 am PPS
		Home Health Agency I	

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMED PRGM (ASSIGNED TIME)		
	15.00	16.00	17.00	19.00	23.00		
1.00 Administrative and General	0	1,517,551	0	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0	0		8.00
9.00 Drugs	0	0	0	0	0		9.00
10.00 DME	0	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0	0		13.00
14.00 Clinic	0	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	0	1,517,551	0	0	0		20.00
21.00 Total cost to be allocated	0	19,874	0	0	0		21.00
22.00 Unit cost multiplier	0.000000	0.013096	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet H-3 Part I Date/Time Prepared: 2/26/2016 9:24 am		
				HHA CCN: 147048	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	564,182		564,182	3,242	174.02	1.00
2.00	Physical Therapy	3.00	468,676	0	468,676	1,989	235.63	2.00
3.00	Occupational Therapy	4.00	11,454	0	11,454	153	74.86	3.00
4.00	Speech Pathology	5.00	0	0	0	43	0.00	4.00
5.00	Medical Social Services	6.00	49,292		49,292	465	106.00	5.00
6.00	Home Health Aide	7.00	43,026		43,026	52	827.42	6.00
7.00	Total (sum of lines 1-6)		1,136,630	0	1,136,630	5,944		7.00
Program Visits								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Part B				
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		16974	0	15			8.00
8.01	Skilled Nursing Care		20994	0	0			8.01
8.02	Skilled Nursing Care		99914	0	1,970			8.02
9.00	Physical Therapy		16974	0	18			9.00
9.01	Physical Therapy		20994	0	5			9.01
9.02	Physical Therapy		99914	0	1,213			9.02
10.00	Occupational Therapy		16974	0	0			10.00
10.01	Occupational Therapy		20994	0	0			10.01
10.02	Occupational Therapy		99914	0	91			10.02
11.00	Speech Pathology		16974	0	0			11.00
11.01	Speech Pathology		20994	0	0			11.01
11.02	Speech Pathology		99914	0	18			11.02
12.00	Medical Social Services		16974	0	0			12.00
12.01	Medical Social Services		20994	0	0			12.01
12.02	Medical Social Services		99914	0	40			12.02
13.00	Home Health Aide		16974	0	0			13.00
13.01	Home Health Aide		20994	0	0			13.01
13.02	Home Health Aide		99914	0	344			13.02
14.00	Total (sum of lines 8-13)			0	3,714			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	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Cost Center Description	Part A	Part B		Part A	Part B			
		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	1,985		0	345,430		1.00
2.00	Physical Therapy	0	1,236		0	291,239		2.00
3.00	Occupational Therapy	0	91		0	6,812		3.00
4.00	Speech Pathology	0	18		0	0		4.00
5.00	Medical Social Services	0	40		0	4,240		5.00
6.00	Home Health Aide	0	344		0	284,632		6.00
7.00	Total (sum of lines 1-6)	0	3,714		0	932,353		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140110

Period: From 10/01/2014

Worksheet H-3

HHA CCN: 147048

To 09/30/2015

Part I
Date/Time Prepared:
2/26/2016 9:24 am

Title XVII I

Home Health
Agency I

PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	345,430						1.00
2.00	Physical Therapy	291,239						2.00
3.00	Occupational Therapy	6,812						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	4,240						5.00
6.00	Home Health Aide	284,632						6.00
7.00	Total (sum of lines 1-6)	932,353						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
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140110 HHA CCN: 147048	Period: From 10/01/2014 To 09/30/2015	Worksheet H-3 Part II Date/Time Prepared: 2/26/2016 9:24 am
		Title XVIII	Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.637391	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.313893	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.851937	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.232617	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.304582	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140110 HHA CCN: 147048	Period: From 10/01/2014 To 09/30/2015	Worksheet H-4 Part I-II Date/Time Prepared: 2/26/2016 9:24 am
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	536,219
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	5,101
13.00	Total PPS Reimbursement - LUPA Episodes		0	12,945
14.00	Total PPS Reimbursement - PEP Episodes		0	41,149
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	786
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	1,157
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	597,357
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	597,357
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	597,357
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	597,357
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	597,357
31.01	Sequestration adjustment (see instructions)		0	11,947
32.00	Interim payments (see instructions)		0	585,410
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: 140110 HHA CCN: 147048	Period: From 10/01/2014 To 09/30/2015	Worksheet H-5 Date/Time Prepared: 2/26/2016 9:24 am PPS
		Home Health Agency I	

		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		585,410	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		585,410	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		585,410	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: 140110

Period: From 10/01/2014

Worksheet K

Hospice CCN: 141570

To 09/30/2015

Date/Time Prepared: 2/26/2016 9:24 am

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	19,133	0	0	67,394	77,507	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	57,576	0	9.00
10.00	Nursing Care	72,282	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	11,186	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	7,144	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	7,878	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	16,413	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	7,656	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	91	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)	117,623	0	0	132,626	94,011	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140110

Period: From 10/01/2014

Worksheet K

Hospice CCN: 141570

To 09/30/2015

Date/Time Prepared: 2/26/2016 9:24 am

		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	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	164,034	622	164,656	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	57,576	0	57,576	-8,020	9.00
10.00	Nursing Care	72,282	0	72,282	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	11,186	0	11,186	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	7,144	0	7,144	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	7,878	0	7,878	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	16,413	0	16,413	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	7,656	0	7,656	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	91	0	91	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	344,260	622	344,882	-8,020	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140110

Period: From 10/01/2014

Worksheet K-1

Hospice CCN: 141570

To 09/30/2015

Date/Time Prepared: 2/26/2016 9:24 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	72,282	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	7,144	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	7,144	0	72,282	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140110

Period: From 10/01/2014

Worksheet K-1

Hospice CCN: 141570

To 09/30/2015

Date/Time Prepared: 2/26/2016 9:24 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	19,133	19,133	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	72,282	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	11,186	0	0	11,186	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	7,144	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		7,878	0	7,878	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)	11,186	7,878	19,133	117,623	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet K-3
		Hospice CCN: 141570		Date/Time Prepared: 2/26/2016 9:24 am

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet K-3
		Hospice CCN: 141570		Date/Time Prepared: 2/26/2016 9:24 am

		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	67,394	67,394	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	57,576	57,576	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		0	0	0	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	7,656	7,656	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	0	132,626	132,626	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140110

Period:

Worksheet K-4

Hospice CCN: 141570

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

Part I
Date/Time Prepared:
2/26/2016 9:24 am

Hospice I

	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
		BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00			
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	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	164,656	0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	49,556	0	0	0	9.00
10.00	Nursing Care	72,282	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	11,186	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	7,144	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	7,878	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	16,413	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	7,656	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	91	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	336,862	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140110

Period: From 10/01/2014

Worksheet K-4

Hospice CCN: 141570

To 09/30/2015

Part I
Date/Time Prepared:
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		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	164,656	164,656		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	49,556	47,383	96,939	9.00
10.00	Nursing Care	0	72,282	69,113	141,395	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	11,186	10,696	21,882	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	7,144	6,831	13,975	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	7,878	7,533	15,411	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	16,413	15,693	32,106	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	7,656	7,320	14,976	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	91	87	178	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	336,862		336,862	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140110

Period:

Worksheet K-4

Hospice CCN: 141570

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

Part II
Date/Time Prepared:
2/26/2016 9:24 am

		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: 140110

Period:

Worksheet K-4

Hospice CCN: 141570

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

Part II
Date/Time Prepared:
2/26/2016 9:24 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-164,656	172,206	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	49,556	9.00
10.00	Nursing Care	0	72,282	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	11,186	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	7,144	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	7,878	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	16,413	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	7,656	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	91	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)		164,656	39.00
40.00	Unit Cost Multiplier		0.956157	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140110

Period:

Worksheet K-5

Hospice CCN: 141570

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

Part I
Date/Time Prepared:
2/26/2016 9:24 am

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
1.00 Administrative and General		0	631	6,057	6,688	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	96,939	0	0	0	96,939	4.00
5.00 Nursing Care	141,395	0	0	22,883	164,278	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	21,882	0	0	3,541	25,423	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	13,975	0	0	2,262	16,237	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	15,411	0	0	2,494	17,905	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	32,106	0	0	0	32,106	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	14,976	0	0	0	14,976	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	178	0	0	0	178	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)	336,862	0	631	37,237	374,730	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 140110	Period: From 10/01/2014	Worksheet K-5
		Hospice CCN: 141570	To 09/30/2015	Part I Date/Time Prepared: 2/26/2016 9:24 am

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	1,518	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	22,008	0	0	0	0	4.00
5.00	Nursing Care	37,297	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	5,772	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	3,686	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	4,065	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	7,289	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	3,400	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	40	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)	85,075	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: 140110

Period: From 10/01/2014

Worksheet K-5

Hospice CCN: 141570

To 09/30/2015

Part I
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description		Hospice I					
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	15,821	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	15,821	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet K-5 Part I Date/Time Prepared: 2/26/2016 9:24 am
		Hospice CCN: 141570		

Cost Center Description		Hospice I				
		SOCI AL SERVI CE	NONPHYSICI AN ANESTHETI STS	PARAMED ED PRGM	Subtotal (col s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments
		17.00	19.00	23.00	24.00	25.00
1.00	Administrative and General	0	0	0	24,027	1.00
2.00	Inpatient - General Care	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	3.00
4.00	Physician Services	0	0	0	118,947	4.00
5.00	Nursing Care	0	0	0	201,575	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	31,195	7.00
8.00	Occupational Therapy	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	19,923	10.00
11.00	Spiritual Counseling	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	21,970	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	15.00
16.00	Other	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	39,395	19.00
20.00	Other - Specify	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	18,376	22.00
23.00	Imaging Services	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	218	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	28.00
29.00	Other	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	475,626	34.00
35.00	Unit Cost Multiplier (see instructions)					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 140110	Period: From 10/01/2014	Worksheet K-5
		Hospice CCN: 141570	To 09/30/2015	Part I
				Date/Time Prepared: 2/26/2016 9:24 am

Cost Center Description		Subtotal	Allocated	Total Hospice	Hospice I	
		(col s. 24 ± 25)	Hospice A&G (See Part 11)	Costs (col s. 26 ± 27)		
		26.00	27.00	28.00		
1.00	Administrative and General					1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	118,947	6,328	125,275		4.00
5.00	Nursing Care	201,575	10,724	212,299		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	31,195	1,660	32,855		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	19,923	1,060	20,983		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	21,970	1,169	23,139		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	39,395	2,096	41,491		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	18,376	978	19,354		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	218	12	230		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	475,626		475,626		34.00
35.00	Unit Cost Multiplier (see instructions)		0.053204			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140110
Hospice CCN: 141570

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

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
1.00 Administrative and General	0	622	19,133	0	6,688	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	96,939	4.00	
5.00 Nursing Care	0	0	72,282	0	164,278	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00	
7.00 Physical Therapy	0	0	11,186	0	25,423	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	7,144	0	16,237	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	7,878	0	17,905	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	32,106	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	14,976	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	178	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	622	117,623		374,730	34.00	
35.00 Total cost to be allocated	0	631	37,237		85,075	35.00	
36.00 Unit Cost Multiplier (see instructions)	0.000000	1.014469	0.316579		0.227030	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140110

Period:

Worksheet K-5

Hospice CCN: 141570

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

Part II
Date/Time Prepared:
2/26/2016 9:24 am

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140110
Hospice CCN: 141570

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

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 9:24 am

Cost Center Description	Hospice I					
	NURSING ADMINISTRATIVE (HOURS SUPPLEMENTED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
	13.00	14.00	15.00	16.00	17.00	
1.00 Administrative and General	0	0	0	1,208,109	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	1,208,109	0	34.00
35.00 Total cost to be allocated	0	0	0	15,821	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.013096	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140110

Period:

Worksheet K-5

Hospice CCN: 141570

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

Part II
Date/Time Prepared:
2/26/2016 9:24 am

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140110
 Hospice CCN: 141570

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

Worksheet K-5
 Part III
 Date/Time Prepared:
 2/26/2016 9:24 am

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCI LLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.641770	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.313893	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.851937	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.304582	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.136269	0	0 6.00
6.01	BLOOD LABORATORY	60.01			6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.232617	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			9.00
10.00	STRESS TESTING	76.00	0.000000	0	0 10.00
10.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	1.188648	0	0 10.01
10.02	SLEEP LAB	76.02	0.468607	0	0 10.02
10.97	CARDIAC REHABILITATION	76.97	0.104086	0	0 10.97
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140110

Period:

Worksheet K-6

Hospice CCN: 141570

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

Date/Time Prepared:
2/26/2016 9:24 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				475,626	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4,578	2.00
3.00	Average cost per diem (line 1 divided by line 2)				103.89	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	2,561				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	266,062				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		905			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		94,020			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		781			10.00
11.00	Aggregate NF cost (line 3 times line 10)		81,138			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			1,112		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			115,526		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140110	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/26/2016 9:24 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		660,739	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		9,082	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)		29.61	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	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)		0	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)		669,821	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