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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/26/2016 12:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2016 Time: 12:39 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARGARET'S HOSPITAL (140143) 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	138,989	-9,308	752,868	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	138,989	-9,308	752,868	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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2016 11:35 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 EAST FIRST ST	PO Box:			1.00
2.00	City: SPRING VALLEY	State: IL	Zip Code: 61362	County: BUREAU	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. MARGARET'S HOSPITAL	140143	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. MARGARET'S HOSPITAL	14U143	99914		06/23/2003	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	ST. MARGARET'S HOSPITAL	141595	99914		07/07/1998				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: 1.00	To: 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)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		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.	1,038	0	0	0	11	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 11:35 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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.	1		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.	10/01/2014	09/30/2015	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	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 11:35 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 11:35 am

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

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

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

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

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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	506,329	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 11:35 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	35HO02	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: SISTERS MARY OF THE PRESENTATION HC	Contractor's Name: NORIDIAN ADMIN SVC	Contractor's Number: 03001	141.00
142.00	Street: 1202 PAGE DR SW PO BOX 10007	PO Box:		142.00
143.00	City: FARGO	State: ND	Zip Code: 58106-0007	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/26/2016 11:35 am

		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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2016 11:35 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	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	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	02/02/2016	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		Y		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	PIP PYMTS WERE ENTERED AS PAYMENT.	Y		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2016 11:35 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DON	TROGLIO			41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. MARGARET'S HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-664-1328	DTROGLIO@ABOUTSMG.ORG			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2016 11:35 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	02/02/2016			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR OF ACCOUNTING		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2016 11:35 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	57	21,897	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)		57	21,897	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		63	24,087	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		63				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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2016 11:35 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,163	546	5,215			1.00
2.00	HMO and other (see instructions)	514	11				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	111	0	125			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)	3,274	546	5,340			7.00
8.00	INTENSIVE CARE UNIT	545	61	786			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		379	706			13.00
14.00	Total (see instructions)	3,819	986	6,832	0.00	514.26	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	6.89	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	521.15	27.00
28.00	Observation Bed Days		424	2,235			28.00
29.00	Ambulance Trips	387					29.00
30.00	Employee discount days (see instruction)			58			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	58	153			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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2016 11:35 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,025	435	1,957	1.00
2.00	HMO and other (see instructions)			98	9		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	1,025	435	1,957	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2016 11:35 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	30,736,772	0	30,736,772	1,079,848.44	28.46	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		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		7,597,035	0	7,597,035	43,447.50	174.86	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)		906,510	115,875	1,022,385	45,957.30	22.25	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		182,837	0	182,837	2,511.75	72.79	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		925,255	0	925,255	5,048.00	183.29	13.00
14.00	Home office salaries & wage-related costs		1,242,170	0	1,242,170	7,689.00	161.55	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)		5,735,496	0	5,735,496			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		232,868	0	232,868			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		242,708	0	242,708			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	157,550	0	157,550	6,240.00	25.25	26.00
27.00	Administrative & General	5.00	2,558,251	-115,875	2,442,376	107,629.07	22.69	27.00
28.00	Administrative & General under contract (see inst.)		1,084,543	0	1,084,543	5,068.84	213.96	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	308,449	0	308,449	17,934.45	17.20	30.00
31.00	Laundry & Linen Service	8.00	0	38,854	38,854	3,464.25	11.22	31.00
32.00	Housekeeping	9.00	402,431	-38,854	363,577	32,873.85	11.06	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	726,777	-568,122	158,655	11,057.76	14.35	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	568,122	568,122	39,596.19	14.35	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	865,882	0	865,882	24,611.31	35.18	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2016 11:35 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	
41.00	Medical Records & Medical Records Library	16.00	1,275,677	0	1,275,677	49,645.35	25.70	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 2/26/2016 11:35 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 III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		24,224,280	0	24,224,280	1,041,469.78	23.26	1.00
2.00	Excluded area salaries (see instructions)		906,510	115,875	1,022,385	45,957.30	22.25	2.00
3.00	Subtotal salaries (line 1 minus line 2)		23,317,770	-115,875	23,201,895	995,512.48	23.31	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,350,262	0	2,350,262	15,248.75	154.13	4.00
5.00	Subtotal wage-related costs (see inst.)		5,735,496	0	5,735,496	0.00	24.72	5.00
6.00	Total (sum of lines 3 thru 5)		31,403,528	-115,875	31,287,653	1,010,761.23	30.95	6.00
7.00	Total overhead cost (see instructions)		7,379,560	-115,875	7,263,685	298,121.07	24.36	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 2/26/2016 11:35 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	704,435	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)	2,834,089	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	154,888	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,474	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	2,858	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	178,160	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	336,161	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	1,516,535	17.00
18.00	Medicare Taxes - Employers Portion Only	443,305	18.00
19.00	Unemployment Insurance	16,916	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	1,253	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,211,074	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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 2/26/2016 11:35 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			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			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/26/2016 11:35 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	Y		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	06/23/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	14	14	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	2	2	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	31	31	28.00
29.00		HE2	0	13	13	29.00
30.00		HE1	0	9	9	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	20	20	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	5	5	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	2	2	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	1	1	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	4	4	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	9	9	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/26/2016 11:35 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	1	1	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	111	111	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0			207.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 140143 Component CCN: 141595	Period: From 10/01/2014 To 09/30/2015	Worksheet S-9 Parts I & II Date/Time Prepared: 2/26/2016 11:35 am
		Hospice I	

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	5,231	0	0	0	205	5,436	2.00
3.00	Inpatient Respite Care	10	0	0	0	0	10	3.00
4.00	General Inpatient Care	61	488	0	0	245	794	4.00
5.00	Total Hospice Days	5,302	488	0	0	450	6,240	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	113	8	0	0	10	131	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)	46.92	61.00	0.00	0.00	45.00	47.63	8.00
9.00	Unduplicated Census Count	105	8	0	0	9	122	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet S-10 Date/Time Prepared: 2/26/2016 11:35 am

		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)	0.339137	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,342,446	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	25,597,135	6.00
7.00	Medicaid cost (line 1 times line 6)	8,680,936	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)	5,338,490	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	175,864	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,338,490	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	1,027,126	737,485	1,764,611	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	348,336	250,108	598,444	21.00
22.00	Partial payment by patients approved for charity care	280,337	195,624	475,961	22.00
23.00	Cost of charity care (line 21 minus line 22)	67,999	54,484	122,483	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,284,982	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	215,234	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,069,748	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	362,791	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	485,274	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,823,764	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/26/2016 11:35 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	NEW CAP REL COSTS-BLDG & FIXT		2,508,720	2,508,720	13,699	2,522,419	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT		45,843	45,843	0	45,843	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,617,926	2,617,926	112,351	2,730,277	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	157,550	6,279,175	6,436,725	0	6,436,725	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,558,251	6,531,447	9,089,698	-155,608	8,934,090	5.00
7.00	00700	OPERATION OF PLANT	308,449	1,966,531	2,274,980	0	2,274,980	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	158,128	158,128	38,854	196,982	8.00
9.00	00900	HOUSEKEEPING	402,431	238,165	640,596	-38,854	601,742	9.00
10.00	01000	DIETARY	726,777	411,113	1,137,890	-889,506	248,384	10.00
11.00	01100	CAFETERIA	0	0	0	889,506	889,506	11.00
13.00	01300	NURSING ADMINISTRATION	865,882	38,508	904,390	0	904,390	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,275,677	236,936	1,512,613	0	1,512,613	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,212,330	1,067,380	3,279,710	-87,971	3,191,739	30.00
31.00	03100	INTENSIVE CARE UNIT	607,467	55,239	662,706	0	662,706	31.00
43.00	04300	NURSERY	92,967	146,328	239,295	0	239,295	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,886,590	3,565,919	5,452,509	0	5,452,509	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	307,117	57,922	365,039	87,971	453,010	52.00
53.00	05300	ANESTHESIOLOGY	0	1,259,966	1,259,966	0	1,259,966	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	787,499	1,392,344	2,179,843	0	2,179,843	54.00
54.01	05402	NUCLEAR MEDICINE	111,730	344,005	455,735	0	455,735	54.01
57.00	05700	CT SCAN	149,603	114,374	263,977	0	263,977	57.00
60.00	06000	LABORATORY	918,126	2,224,098	3,142,224	0	3,142,224	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	219,503	219,503	0	219,503	63.00
65.00	06500	RESPIRATORY THERAPY	417,032	63,883	480,915	0	480,915	65.00
66.00	06600	PHYSICAL THERAPY	1,164,140	128,311	1,292,451	0	1,292,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	88,482	86,138	174,620	0	174,620	67.00
68.00	06800	SPEECH PATHOLOGY	70,615	2,814	73,429	0	73,429	68.00
69.00	06900	ELECTROCARDIOLOGY	132,038	76,786	208,824	0	208,824	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,297	9,551	83,848	0	83,848	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,355	216,471	256,826	1,337	258,163	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,964,619	2,964,619	0	2,964,619	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	659,238	1,809,918	2,469,156	-1,337	2,467,819	73.00
76.00	03020	SONOGRAPHY	144,577	318,794	463,371	0	463,371	76.00
76.01	03040	AUDIOLOGY	0	0	0	228,438	228,438	76.01
76.02	03160	CARDIAC REHAB	157,691	12,237	169,928	0	169,928	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	12,738,492	2,934,290	15,672,782	397,583	16,070,365	90.00
91.00	09100	EMERGENCY	774,859	1,535,497	2,310,356	0	2,310,356	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	351	503,235	503,586	0	503,586	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		785,843	785,843	-785,843	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	390,030	409,994	800,024	0	800,024	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,220,643	43,337,951	73,558,594	-189,380	73,369,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	30,301	4,324	34,625	0	34,625	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	46,827	14,935	61,762	0	61,762	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	1,686	1,686	0	1,686	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	194,917	387,931	582,848	0	582,848	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/26/2016 11:35 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	
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	160,297	160,297	194.20
194.21	07971	OCCUPATIONAL HEALTH	179,802	59,921	239,723	29,083	268,806	194.21
194.24	07974	SURGICAL ASSOCIATES	0	356	356	0	356	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	64,282	1,061	65,343	0	65,343	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
200.00		TOTAL (SUM OF LINES 118-199)	30,736,772	43,808,165	74,544,937	0	74,544,937	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-52,521	2,469,898		1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	45,843		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	6,614	2,736,891		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	95	95		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,120,536	5,316,189		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-382,833	8,551,257		5.00
7.00	00700	OPERATION OF PLANT	-1,800	2,273,180		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	196,982		8.00
9.00	00900	HOUSEKEEPING	0	601,742		9.00
10.00	01000	DIETARY	-4,054	244,330		10.00
11.00	01100	CAFETERIA	-187,917	701,589		11.00
13.00	01300	NURSING ADMINISTRATION	0	904,390		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,173	1,510,440		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-824,301	2,367,438		30.00
31.00	03100	INTENSIVE CARE UNIT	0	662,706		31.00
43.00	04300	NURSERY	-118,929	120,366		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,452,509		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	453,010		52.00
53.00	05300	ANESTHESIOLOGY	-1,072,499	187,467		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,179,843		54.00
54.01	05402	NUCLEAR MEDICINE	0	455,735		54.01
57.00	05700	CT SCAN	0	263,977		57.00
60.00	06000	LABORATORY	0	3,142,224		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	219,503		63.00
65.00	06500	RESPIRATORY THERAPY	0	480,915		65.00
66.00	06600	PHYSICAL THERAPY	-26,326	1,266,125		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	174,620		67.00
68.00	06800	SPEECH PATHOLOGY	0	73,429		68.00
69.00	06900	ELECTROCARDIOLOGY	-20,800	188,024		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	83,848		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	258,163		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,964,619		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-341,159	2,126,660		73.00
76.00	03020	SONOGRAPHY	-40,100	423,271		76.00
76.01	03040	AUDIOLOGY	0	228,438		76.01
76.02	03160	CARDIAC REHAB	0	169,928		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	-7,620,114	8,450,251		90.00
91.00	09100	EMERGENCY	-1,106,114	1,204,242		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	503,586		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	800,024		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,915,467	60,453,747		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0		194.00
194.01	07951	CONGREGATE LIVING	0	34,625		194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0		194.02
194.03	07953	MANAGED CARE	0	61,762		194.03
194.04	07954	RENTAL AREA/PPOS	0	0		194.04
194.05	07955	SPECIALTY CLINICS	0	1,686		194.05
194.08	07958	ENT	0	0		194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	582,848		194.09
194.10	07960	PERU MALL	0	0		194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0		194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0		194.13
194.14	07964	HENRY	0	0		194.14
194.16	07966	SPRING VALLEY CLINIC	0	0		194.16
194.17	07967	OGLESBY MP OB	0	0		194.17
194.18	07968	FAMILY HEALTH CENTER	0	0		194.18
194.19	07969	GRANVILLE CLINIC	0	0		194.19
194.20	07970	PARATRANSIT	0	160,297		194.20

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.21	07971	OCCUPATIONAL HEALTH	0	268,806		194.21
194.24	07974	SURGICAL ASSOCIATES	0	356		194.24
194.27	07977	MIDTOWN	0	0		194.27
194.28	07978	PAIN CLINIC	0	65,343		194.28
194.30	07980	WHC-PTON	0	0		194.30
200.00		TOTAL (SUM OF LINES 118-199)	-12,915,467	61,629,470		200.00

RECLASSIFICATIONS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/26/2016 11:35 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - IV COSTS FROM PHARMACY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,337		1.00
	TOTALS		0	1,337		
	B - DIETARY RECLASS					
1.00	CAFETERIA	11.00	568,122	321,384		1.00
	TOTALS		568,122	321,384		
	C - LAUNDRY SALARIES					
1.00	LAUNDRY & LINEN SERVICE	8.00	38,854	0		1.00
	TOTALS		38,854	0		
	D - DEPRECIATION FOR OFF CAMPUS CLINICS					
1.00	CLINIC	90.00	0	626,021		1.00
2.00	OCCUPATIONAL HEALTH	194.21	0	29,083		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	655,104		
	E - AUDIOLOGY COSTS					
1.00	AUDIOLOGY	76.01	0	228,438		1.00
	TOTALS		0	228,438		
	F - INTEREST EXPENSE ON EQUIPMENT					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	112,351		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4,689		2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	668,803		3.00
	TOTALS		0	785,843		
	G - PARATRANSIT COSTS					
1.00	PARATRANSIT	194.20	115,875	44,422		1.00
	TOTALS		115,875	44,422		
	H - LABOR AND DELIVERY SALARIES					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	87,971	0		1.00
	TOTALS		87,971	0		
500.00	Grand Total: Increases		810,822	2,036,528		500.00

RECLASSIFICATIONS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/26/2016 11:35 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - IV COSTS FROM PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,337	0		1.00
	TOTALS		0	1,337			
	B - DIETARY RECLASS						
1.00	DIETARY	10.00	568,122	321,384	0		1.00
	TOTALS		568,122	321,384			
	C - LAUNDRY SALARIES						
1.00	HOUSEKEEPING	9.00	38,854	0	0		1.00
	TOTALS		38,854	0			
	D - DEPRECIATION FOR OFF CAMPUS CLINICS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	655,104	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	655,104			
	E - AUDIOLOGY COSTS						
1.00	CLINIC	90.00	0	228,438	0		1.00
	TOTALS		0	228,438			
	F - INTEREST EXPENSE ON EQUIPMENT						
1.00	INTEREST EXPENSE	113.00	0	785,843	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	785,843			
	G - PARATRANSIT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	115,875	44,422	0		1.00
	TOTALS		115,875	44,422			
	H - LABOR AND DELIVERY SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	87,971	0	0		1.00
	TOTALS		87,971	0			
500.00	Grand Total: Decreases		810,822	2,036,528			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I Date/Time Prepared: 2/26/2016 11:35 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,464,302	298,026	0	298,026	0	1.00
2.00	Land Improvements	2,589,919	13,840	0	13,840	3,600	2.00
3.00	Buildings and Fixtures	58,511,901	5,046,045	0	5,046,045	1,391,833	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	27,615,824	2,609,258	0	2,609,258	4,840,449	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	91,181,946	7,967,169	0	7,967,169	6,235,882	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	91,181,946	7,967,169	0	7,967,169	6,235,882	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,762,328	0				1.00
2.00	Land Improvements	2,600,159	0				2.00
3.00	Buildings and Fixtures	62,166,113	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	25,384,633	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	92,913,233	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	92,913,233	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2016 11:35 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	NEW CAP REL COSTS-BLDG & FIXT	2,508,720	0	0	0	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	45,843	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,617,926	0	0	0	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	5,172,489	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,508,720	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	45,843	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,617,926	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	2.01
3.00	Total (sum of lines 1-2)	0	5,172,489	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2016 11:35 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	NEW CAP REL COSTS-BLDG & FIXT	66,445,305	0	66,445,305	0.715133	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	1,083,295	0	1,083,295	0.011659	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	25,373,954	0	25,373,954	0.273093	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	10,679	0	10,679	0.000115	0	2.01
3.00	Total (sum of lines 1-2)	92,913,233	0	92,913,233	0.000000	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,853,616	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	45,843	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,624,540	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	95	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,524,094	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	NEW CAP REL COSTS-BLDG & FIXT	616,282	0	0	0	2,469,898	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	45,843	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	112,351	0	0	0	2,736,891	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	95	2.01
3.00	Total (sum of lines 1-2)	728,633	0	0	0	5,252,727	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/26/2016 11:35 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-51,798	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-28,786	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,800	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,998,749			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	-17,336			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-187,917	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-341,159	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,173	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-4,054	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - OLD CAP REL COSTS-BLDG & FIXT		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - OLD CAP REL COSTS-MVBLE EQUIP		0	OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/26/2016 11:35 am

	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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01	OUTSIDE PHYSICAL THERAPY	B	-26,326	PHYSICAL THERAPY	66.00	0	33.01
33.03	OB COMISSIONS	B	-68	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HOME OFFICE OPERATING INTEREST INCOM	B	-723	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.04
33.06	PATIENT PHONES	A	-17,331	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT PHONES DEPRECIATION	A	-9,061	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.10	MISC INCOME	B	-3,392	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PHYSICIAN RECRUITMENT	A	-260,789	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	EMPLOYEE HEALTH	A	-877,828	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	PHYSICIAN RECRUITMENT - CLINIC	A	-16,970	CLINIC	90.00	0	33.13
33.15	ADMIN COSTS FOR POB	A	1,023	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16			0		0.00	0	33.16
33.17	LOBBYING PORTION OF IHHA DUES	A	-28,863	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18			0		0.00	0	33.18
34.00	MISC REVENUE	B	-6,738	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	HOSPITALIST RECEPTIONIST & OTHER EXP	A	-29,846	ADULTS & PEDIATRICS	30.00	0	35.00
36.00	LEADERSHIP CONFERENCE SPOUSE COSTS	A	-4,783	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00			0		0.00	0	37.00
38.00			0		0.00	0	38.00
39.00			0		0.00	0	39.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
44.00			0		0.00	0	44.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,915,467				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: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/26/2016 11:35 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	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,358,562	1,387,668	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SISTERS SALARIES	0	4,000	2.00
3.00	2.01	OLD CAP REL COSTS-MVBLE EQUI	OLD CAPITAL COSTS	95	0	3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	NEW CAPITAL COSTS	15,675	0	4.00
5.00	0		0	1,374,332	1,391,668	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		
	Symbol (1)	Name	Percentage of Ownership	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	SRS OF MARY OF THE PRES	100.00	6.00
7.00	G	SMP HEALTH CORP	0.00	SMP HEALTH CORP	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:	NON-FINANCIAL				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: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/26/2016 11:35 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	-29,106	0		1.00
2.00	-4,000	0		2.00
3.00	95	9		3.00
4.00	15,675	9		4.00
5.00	-17,336			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	RELIGIOUS COMMUNITY		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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2016 11:35 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	53.00	ANESTHESIOLOGY	1,103,000	962,597	140,403	239,400	265	1.00
2.00	91.00	EMERGENCY	1,427,712	818,650	609,062	179,000	3,737	2.00
3.00	43.00	NURSERY	118,929	118,929	0	0	0	3.00
4.00	60.00	LABORATORY	35,000	0	35,000	260,300	520	4.00
5.00	69.00	ELECTROCARDIOLOGY	20,800	20,800	0	0	0	5.00
6.00	76.00	SONOGRAPHY	40,100	40,100	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	715,697	710,689	5,008	211,500	22	7.00
8.00	30.00	ADULTS & PEDIATRICS	164,782	0	164,782	211,500	824	8.00
9.00	90.00	CLINIC	7,597,035	7,597,035	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	242,708	242,708	0	0	0	10.00
11.00	90.00	CLINIC	6,109	6,109	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	6,000	0	6,000	211,500	200	12.00
200.00			11,477,872	10,517,617	960,255		5,568	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	53.00	ANESTHESIOLOGY	30,501	1,525	0	0	0	1.00
2.00	91.00	EMERGENCY	321,598	16,080	0	0	0	2.00
3.00	43.00	NURSERY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	65,075	3,254	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.00	SONOGRAPHY	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	2,237	112	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	83,787	4,189	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	20,337	1,017	0	0	0	12.00
200.00			523,535	26,177	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	53.00	ANESTHESIOLOGY	0	30,501	109,902	1,072,499		1.00
2.00	91.00	EMERGENCY	0	321,598	287,464	1,106,114		2.00
3.00	43.00	NURSERY	0	0	0	118,929		3.00
4.00	60.00	LABORATORY	0	65,075	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	20,800		5.00
6.00	76.00	SONOGRAPHY	0	0	0	40,100		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	2,237	2,771	713,460		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	83,787	80,995	80,995		8.00
9.00	90.00	CLINIC	0	0	0	7,597,035		9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	242,708		10.00
11.00	90.00	CLINIC	0	0	0	6,109		11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	0	20,337	0	0		12.00
200.00			0	523,535	481,132	10,998,749		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,469,898	2,469,898				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	45,843	0	45,843			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,736,891			2,736,891		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	95			0	95	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,316,189	9,255	172	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,551,257	738,110	13,698	1,051,473	95	5.00
7.00	00700	OPERATION OF PLANT	2,273,180	256,742	4,765	65,202	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	196,982	6,644	123	0	0	8.00
9.00	00900	HOUSEKEEPING	601,742	26,519	492	98	0	9.00
10.00	01000	DIETARY	244,330	68,242	1,267	27,267	0	10.00
11.00	01100	CAFETERIA	701,589	22,678	421	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	904,390	27,397	509	1,736	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510,440	35,104	652	38,367	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,367,438	210,366	3,905	104,490	0	30.00
31.00	03100	INTENSIVE CARE UNIT	662,706	42,636	791	13,508	0	31.00
43.00	04300	NURSERY	120,366	10,217	190	55,680	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,452,509	229,947	4,268	633,393	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	453,010	5,146	96	9,663	0	52.00
53.00	05300	ANESTHESIOLOGY	187,467	3,858	72	5,852	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,179,843	67,070	1,245	215,809	0	54.00
54.01	05402	NUCLEAR MEDICINE	455,735	17,556	326	91,531	0	54.01
57.00	05700	CT SCAN	263,977	5,439	101	75,523	0	57.00
60.00	06000	LABORATORY	3,142,224	32,711	607	57,260	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	219,503	1,958	36	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	480,915	9,791	182	13,214	0	65.00
66.00	06600	PHYSICAL THERAPY	1,266,125	87,505	1,624	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	174,620	326	6	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	73,429	1,473	27	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	188,024	1,105	21	23,418	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	83,848	11,146	207	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	258,163	65,154	1,209	28,483	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,964,619	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,126,660	23,933	444	16,493	0	73.00
76.00	03020	SONOGRAPHY	423,271	4,477	83	46,214	0	76.00
76.01	03040	AUDIOLOGY	228,438	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	169,928	12,477	232	9,424	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	8,450,251	141,923	2,634	127,334	0	90.00
91.00	09100	EMERGENCY	1,204,242	46,050	855	3,033	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	503,586	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	800,024	8,151	151	201	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,453,747	2,231,106	41,411	2,714,666	95	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,171	207	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	34,625	111,078	2,062	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	61,762	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	92,275	1,713	0	0	194.04
194.05	07955	SPECIALTY CLINICS	1,686	0	0	1,558	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	582,848	24,268	450	4,900	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	160,297	0	0	10,652	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	268,806	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	356	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	5,115	0	194.27
194.28	07978	PAIN CLINIC	65,343	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	61,629,470	2,469,898	45,843	2,736,891	95	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,325,616					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	566,463	10,921,096	10,921,096			5.00
7.00	00700	OPERATION OF PLANT	71,539	2,671,428	575,348	3,246,776		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,011	212,760	45,822	14,717	273,299	8.00
9.00	00900	HOUSEKEEPING	84,325	713,176	153,597	58,739	0	9.00
10.00	01000	DIETARY	36,797	377,903	81,389	151,158	0	10.00
11.00	01100	CAFETERIA	131,765	856,453	184,455	50,232	0	11.00
13.00	01300	NURSING ADMINISTRATION	200,825	1,134,857	244,415	60,686	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	295,869	1,880,432	404,991	77,757	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	488,034	3,174,233	683,638	465,967	177,733	30.00
31.00	03100	INTENSIVE CARE UNIT	140,890	860,531	185,333	94,439	14,567	31.00
43.00	04300	NURSERY	21,562	208,015	44,800	22,632	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	437,559	6,757,676	1,455,407	509,342	28,969	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,633	559,548	120,510	11,399	0	52.00
53.00	05300	ANESTHESIOLOGY	0	197,249	42,482	8,545	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	182,645	2,646,612	570,003	148,563	18,229	54.00
54.01	05402	NUCLEAR MEDICINE	25,914	591,062	127,298	38,888	0	54.01
57.00	05700	CT SCAN	34,698	379,738	81,785	12,048	3,635	57.00
60.00	06000	LABORATORY	212,942	3,445,744	742,113	72,456	137	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	221,497	47,704	4,337	0	63.00
65.00	06500	RESPIRATORY THERAPY	96,723	600,825	129,400	21,687	534	65.00
66.00	06600	PHYSICAL THERAPY	270,000	1,625,254	350,033	193,827	14,567	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,522	195,474	42,099	723	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,378	91,307	19,665	3,262	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,624	243,192	52,377	2,447	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	17,232	112,433	24,215	24,689	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,360	362,369	78,044	144,318	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,964,619	638,493	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	152,898	2,320,428	499,753	53,012	0	73.00
76.00	03020	SONOGRAPHY	33,532	507,577	109,317	9,917	0	76.00
76.01	03040	AUDIOLOGY	0	228,438	49,199	0	0	76.01
76.02	03160	CARDIAC REHAB	36,573	228,634	49,241	27,637	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,192,466	9,914,608	2,135,303	314,364	0	90.00
91.00	09100	EMERGENCY	179,714	1,433,894	308,819	102,002	14,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	81	503,667	108,475	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	90,460	898,987	193,616	18,054	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,179,034	60,041,716	10,579,139	2,717,844	272,938	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,378	2,450	24,745	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	7,028	154,793	33,338	246,042	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	10,861	72,623	15,641	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	93,988	20,242	204,392	0	194.04
194.05	07955	SPECIALTY CLINICS	0	3,244	699	0	361	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	45,207	657,673	141,644	53,753	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	26,875	197,824	42,606	0	0	194.20

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
194.21	07971	OCCUPATIONAL HEALTH	41,702	310,508	66,874	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	356	77	0	0	194.24
194.27	07977	MIDTOWN	0	5,115	1,102	0	0	194.27
194.28	07978	PAIN CLINIC	14,909	80,252	17,284	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,325,616	61,629,470	10,921,096	3,246,776	273,299	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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	925,512					9.00
10.00	01000	DIETARY	45,950	656,400				10.00
11.00	01100	CAFETERIA	36,653	0	1,127,793			11.00
13.00	01300	NURSING ADMINISTRATION	27,560	0	48,525	1,516,043		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	55,705	0	139,688	0	2,558,573	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	353,687	452,878	221,209	628,000	133,405	30.00
31.00	03100	INTENSIVE CARE UNIT	45,568	81,987	48,803	138,497	21,379	31.00
43.00	04300	NURSERY	4,177	0	13,904	39,505	9,101	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,687	148	165,225	469,078	418,920	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,466	0	25,954	73,683	13,559	52.00
53.00	05300	ANESTHESIOLOGY	764	0	0	0	74,990	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,381	0	69,890	0	161,983	54.00
54.01	05402	NUCLEAR MEDICINE	1,656	0	10,428	0	31,442	54.01
57.00	05700	CT SCAN	1,656	0	6,906	0	195,191	57.00
60.00	06000	LABORATORY	18,441	0	88,336	0	361,479	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,936	0	0	0	5,612	63.00
65.00	06500	RESPIRATORY THERAPY	4,457	0	31,979	0	38,248	65.00
66.00	06600	PHYSICAL THERAPY	9,170	0	0	0	111,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	12,747	67.00
68.00	06800	SPEECH PATHOLOGY	1,656	0	0	0	4,357	68.00
69.00	06900	ELECTROCARDIOLOGY	2,878	0	10,104	0	50,241	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	662	0	7,833	0	14,383	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,457	0	6,720	0	121,375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	57,572	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,441	0	37,355	0	86,906	73.00
76.00	03020	SONOGRAPHY	1,656	0	9,455	0	71,159	76.00
76.01	03040	AUDIOLOGY	1,656	0	0	0	6,114	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	11,143	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	76,008	0	80,581	90.00
91.00	09100	EMERGENCY	18,441	0	58,906	167,280	103,972	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	6,403	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	31,933	0	34,507	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	776,761	535,013	1,109,161	1,516,043	2,238,387	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,656	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	78,835	194.00
194.01	07951	CONGREGATE LIVING	0	121,387	3,847	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	35,294	194.02
194.03	07953	MANAGED CARE	0	0	3,708	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	147,095	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	6,041	194.05
194.08	07958	ENT	0	0	0	0	21,316	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	7,756	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	45,198	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	36,460	194.13
194.14	07964	HENRY	0	0	0	0	1,635	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	6,926	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	1,945	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	31,958	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	4,766	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
194.21	07971	OCCUPATIONAL HEALTH	0	0	11,077	0	6,238	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	33,277	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	449	194.28
194.30	07980	WHC-PTON	0	0	0	0	2,092	194.30
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)	925,512	656,400	1,127,793	1,516,043	2,558,573	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,290,750	0	6,290,750		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,491,104	0	1,491,104		31.00
43.00	04300	NURSERY	0	342,134	0	342,134		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,878,452	0	9,878,452		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	823,119	0	823,119		52.00
53.00	05300	ANESTHESIOLOGY	0	324,030	0	324,030		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,642,661	0	3,642,661		54.00
54.01	05402	NUCLEAR MEDICINE	0	800,774	0	800,774		54.01
57.00	05700	CT SCAN	0	680,959	0	680,959		57.00
60.00	06000	LABORATORY	0	4,728,706	0	4,728,706		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	281,086	0	281,086		63.00
65.00	06500	RESPIRATORY THERAPY	0	827,130	0	827,130		65.00
66.00	06600	PHYSICAL THERAPY	0	2,304,469	0	2,304,469		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	251,043	0	251,043		67.00
68.00	06800	SPEECH PATHOLOGY	0	120,247	0	120,247		68.00
69.00	06900	ELECTROCARDIOLOGY	0	361,239	0	361,239		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	184,215	0	184,215		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	717,283	0	717,283		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,660,684	0	3,660,684		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,015,895	0	3,015,895		73.00
76.00	03020	SONOGRAPHY	0	709,081	0	709,081		76.00
76.01	03040	AUDIOLOGY	0	285,407	0	285,407		76.01
76.02	03160	CARDIAC REHAB	0	316,655	0	316,655		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	12,520,864	0	12,520,864		90.00
91.00	09100	EMERGENCY	0	2,207,881	0	2,207,881		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	618,545	0	618,545		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,177,097	0	1,177,097		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	58,561,510	0	58,561,510		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,229	0	40,229		190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	78,835	0	78,835		194.00
194.01	07951	CONGREGATE LIVING	0	559,407	0	559,407		194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	35,294	0	35,294		194.02
194.03	07953	MANAGED CARE	0	91,972	0	91,972		194.03
194.04	07954	RENTAL AREA/PPOS	0	465,717	0	465,717		194.04
194.05	07955	SPECIALTY CLINICS	0	10,345	0	10,345		194.05
194.08	07958	ENT	0	21,316	0	21,316		194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	860,826	0	860,826		194.09
194.10	07960	PERU MALL	0	0	0	0		194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	45,198	0	45,198		194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	36,460	0	36,460		194.13
194.14	07964	HENRY	0	1,635	0	1,635		194.14
194.16	07966	SPRING VALLEY CLINIC	0	6,926	0	6,926		194.16
194.17	07967	OGLESBY MP OB	0	1,945	0	1,945		194.17
194.18	07968	FAMILY HEALTH CENTER	0	31,958	0	31,958		194.18

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	4,766	0	4,766		194.19
194.20	07970	PARATRANSIT	0	240,430	0	240,430		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	394,697	0	394,697		194.21
194.24	07974	SURGICAL ASSOCIATES	0	433	0	433		194.24
194.27	07977	MIDTOWN	0	39,494	0	39,494		194.27
194.28	07978	PAIN CLINIC	0	97,985	0	97,985		194.28
194.30	07980	WHC-PTON	0	2,092	0	2,092		194.30
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	61,629,470	0	61,629,470		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS OLD BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	CAPITAL RELATED COSTS OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,255	172	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,422	738,110	13,698	1,051,473	95	5.00
7.00	00700	OPERATION OF PLANT	52,382	256,742	4,765	65,202	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,644	123	0	0	8.00
9.00	00900	HOUSEKEEPING	3,491	26,519	492	98	0	9.00
10.00	01000	DIETARY	0	68,242	1,267	27,267	0	10.00
11.00	01100	CAFETERIA	0	22,678	421	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	27,397	509	1,736	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,104	652	38,367	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,821	210,366	3,905	104,490	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,044	42,636	791	13,508	0	31.00
43.00	04300	NURSERY	0	10,217	190	55,680	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,396	229,947	4,268	633,393	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,146	96	9,663	0	52.00
53.00	05300	ANESTHESIOLOGY	28,630	3,858	72	5,852	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	381,420	67,070	1,245	215,809	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	17,556	326	91,531	0	54.01
57.00	05700	CT SCAN	0	5,439	101	75,523	0	57.00
60.00	06000	LABORATORY	0	32,711	607	57,260	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,958	36	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,041	9,791	182	13,214	0	65.00
66.00	06600	PHYSICAL THERAPY	14,775	87,505	1,624	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	326	6	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,473	27	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,105	21	23,418	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,146	207	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,154	1,209	28,483	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	16,956	23,933	444	16,493	0	73.00
76.00	03020	SONOGRAPHY	0	4,477	83	46,214	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	12,477	232	9,424	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	10,622	141,923	2,634	127,334	0	90.00
91.00	09100	EMERGENCY	13,422	46,050	855	3,033	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	36,075	8,151	151	201	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	774,497	2,231,106	41,411	2,714,666	95	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,171	207	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	111,078	2,062	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	92,275	1,713	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	1,558	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	24,268	450	4,900	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	10,652	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	5,115	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	774,497	2,469,898	45,843	2,736,891	95	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,427	9,427				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,825,798	1,004	1,826,802			5.00
7.00	00700	OPERATION OF PLANT	379,091	127	96,241	475,459		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,767	16	7,665	2,155	16,603	8.00
9.00	00900	HOUSEKEEPING	30,600	149	25,693	8,602	0	9.00
10.00	01000	DIETARY	96,776	65	13,614	22,136	0	10.00
11.00	01100	CAFETERIA	23,099	233	30,855	7,356	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,642	356	40,884	8,887	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	74,123	524	67,744	11,387	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	337,582	865	114,355	68,236	10,798	30.00
31.00	03100	INTENSIVE CARE UNIT	73,979	250	31,001	13,830	885	31.00
43.00	04300	NURSERY	66,087	38	7,494	3,314	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,017,004	775	243,452	74,588	1,760	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,905	162	20,158	1,669	0	52.00
53.00	05300	ANESTHESIOLOGY	38,412	0	7,106	1,251	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	665,544	324	95,347	21,756	1,107	54.00
54.01	05402	NUCLEAR MEDICINE	109,413	46	21,294	5,695	0	54.01
57.00	05700	CT SCAN	81,063	61	13,680	1,764	221	57.00
60.00	06000	LABORATORY	90,578	377	124,136	10,610	8	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,994	0	7,980	635	0	63.00
65.00	06500	RESPIRATORY THERAPY	32,228	171	21,645	3,176	32	65.00
66.00	06600	PHYSICAL THERAPY	103,904	478	58,551	28,384	885	66.00
67.00	06700	OCCUPATIONAL THERAPY	332	36	7,042	106	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,500	29	3,289	478	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,544	54	8,761	358	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	11,353	31	4,051	3,616	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	94,846	17	13,055	21,134	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	106,803	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,826	271	83,596	7,763	0	73.00
76.00	03020	SONOGRAPHY	50,774	59	18,286	1,452	0	76.00
76.01	03040	AUDIOLOGY	0	0	8,230	0	0	76.01
76.02	03160	CARDIAC REHAB	22,133	65	8,237	4,047	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	282,513	2,107	357,168	46,036	0	90.00
91.00	09100	EMERGENCY	63,360	318	51,657	14,937	885	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	18,145	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	44,578	160	32,387	2,644	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,761,775	9,168	1,769,602	398,002	16,581	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,378	0	410	3,624	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	113,140	12	5,577	36,030	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	19	2,616	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	93,988	0	3,386	29,931	0	194.04
194.05	07955	SPECIALTY CLINICS	1,558	0	117	0	22	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	29,618	80	23,693	7,872	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	10,652	48	7,127	0	0	194.20

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
194.21	07971	OCCUPATIONAL HEALTH	0	74	11,186	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	13	0	0	194.24
194.27	07977	MIDTOWN	5,115	0	184	0	0	194.27
194.28	07978	PAIN CLINIC	0	26	2,891	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,027,224	9,427	1,826,802	475,459	16,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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	65,044					9.00
10.00	01000	DIETARY	3,229	135,820				10.00
11.00	01100	CAFETERIA	2,576	0	64,119			11.00
13.00	01300	NURSING ADMINISTRATION	1,937	0	2,759	84,465		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,915	0	7,942	0	165,635	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,859	93,707	12,575	34,989	8,641	30.00
31.00	03100	INTENSIVE CARE UNIT	3,202	16,965	2,775	7,716	1,385	31.00
43.00	04300	NURSERY	294	0	790	2,201	589	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,179	31	9,394	26,134	27,042	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,298	0	1,476	4,105	878	52.00
53.00	05300	ANESTHESIOLOGY	54	0	0	0	4,857	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,924	0	3,974	0	10,492	54.00
54.01	05402	NUCLEAR MEDICINE	116	0	593	0	2,037	54.01
57.00	05700	CT SCAN	116	0	393	0	12,643	57.00
60.00	06000	LABORATORY	1,296	0	5,022	0	23,414	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	136	0	0	0	364	63.00
65.00	06500	RESPIRATORY THERAPY	313	0	1,818	0	2,477	65.00
66.00	06600	PHYSICAL THERAPY	644	0	0	0	7,230	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	826	67.00
68.00	06800	SPEECH PATHOLOGY	116	0	0	0	282	68.00
69.00	06900	ELECTROCARDIOLOGY	202	0	574	0	3,254	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	47	0	445	0	932	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	313	0	382	0	7,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,729	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,296	0	2,124	0	5,629	73.00
76.00	03020	SONOGRAPHY	116	0	538	0	4,609	76.00
76.01	03040	AUDIOLOGY	116	0	0	0	396	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	722	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	4,321	0	5,220	90.00
91.00	09100	EMERGENCY	1,296	0	3,349	9,320	6,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	415	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	1,815	0	2,235	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,590	110,703	63,059	84,465	144,895	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	116	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	5,106	194.00
194.01	07951	CONGREGATE LIVING	0	25,117	219	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	2,286	194.02
194.03	07953	MANAGED CARE	0	0	211	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	10,338	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	391	194.05
194.08	07958	ENT	0	0	0	0	1,381	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	502	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	2,928	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	2,362	194.13
194.14	07964	HENRY	0	0	0	0	106	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	449	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	126	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	2,070	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	309	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
194.21	07971	OCCUPATIONAL HEALTH	0	0	630	0	404	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	2,156	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	29	194.28
194.30	07980	WHC-PTON	0	0	0	0	135	194.30
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)	65,044	135,820	64,119	84,465	165,635	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	706,607	0	706,607		30.00
31.00	03100	INTENSIVE CARE UNIT	0	151,988	0	151,988		31.00
43.00	04300	NURSERY	0	80,807	0	80,807		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,405,359	0	1,405,359		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,651	0	44,651		52.00
53.00	05300	ANESTHESIOLOGY	0	51,680	0	51,680		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	800,468	0	800,468		54.00
54.01	05402	NUCLEAR MEDICINE	0	139,194	0	139,194		54.01
57.00	05700	CT SCAN	0	109,941	0	109,941		57.00
60.00	06000	LABORATORY	0	255,441	0	255,441		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,109	0	11,109		63.00
65.00	06500	RESPIRATORY THERAPY	0	61,860	0	61,860		65.00
66.00	06600	PHYSICAL THERAPY	0	200,076	0	200,076		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,342	0	8,342		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,694	0	5,694		68.00
69.00	06900	ELECTROCARDIOLOGY	0	37,747	0	37,747		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	20,475	0	20,475		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	137,609	0	137,609		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	110,532	0	110,532		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	158,505	0	158,505		73.00
76.00	03020	SONOGRAPHY	0	75,834	0	75,834		76.00
76.01	03040	AUDIOLOGY	0	8,742	0	8,742		76.01
76.02	03160	CARDIAC REHAB	0	35,204	0	35,204		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	697,365	0	697,365		90.00
91.00	09100	EMERGENCY	0	151,857	0	151,857		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	18,560	0	18,560		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	83,819	0	83,819		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,569,466	0	5,569,466		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,528	0	15,528		190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	5,106	0	5,106		194.00
194.01	07951	CONGREGATE LIVING	0	180,095	0	180,095		194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	2,286	0	2,286		194.02
194.03	07953	MANAGED CARE	0	2,846	0	2,846		194.03
194.04	07954	RENTAL AREA/PPOS	0	137,643	0	137,643		194.04
194.05	07955	SPECIALTY CLINICS	0	2,088	0	2,088		194.05
194.08	07958	ENT	0	1,381	0	1,381		194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	61,765	0	61,765		194.09
194.10	07960	PERU MALL	0	0	0	0		194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	2,928	0	2,928		194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	2,362	0	2,362		194.13
194.14	07964	HENRY	0	106	0	106		194.14
194.16	07966	SPRING VALLEY CLINIC	0	449	0	449		194.16
194.17	07967	OGLESBY MP OB	0	126	0	126		194.17
194.18	07968	FAMILY HEALTH CENTER	0	2,070	0	2,070		194.18

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	309	0	309		194.19
194.20	07970	PARATRANSIT	0	17,827	0	17,827		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	12,294	0	12,294		194.21
194.24	07974	SURGICAL ASSOCIATES	0	13	0	13		194.24
194.27	07977	MIDTOWN	0	7,455	0	7,455		194.27
194.28	07978	PAIN CLINIC	0	2,946	0	2,946		194.28
194.30	07980	WHC-PTON	0	135	0	135		194.30
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	6,027,224	0	6,027,224		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	295,156					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	295,156				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,617,926			2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP			0	95		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,106	1,106	0	0	22,962,047	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	88,205	88,205	1,005,769	95	2,442,376	5.00
7.00	00700	OPERATION OF PLANT	30,681	30,681	62,368	0	308,449	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	38,854	8.00
9.00	00900	HOUSEKEEPING	3,169	3,169	94	0	363,577	9.00
10.00	01000	DIETARY	8,155	8,155	26,082	0	158,655	10.00
11.00	01100	CAFETERIA	2,710	2,710	0	0	568,122	11.00
13.00	01300	NURSING ADMINISTRATION	3,274	3,274	1,661	0	865,882	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,195	4,195	36,699	0	1,275,677	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,139	25,139	99,948	0	2,104,220	30.00
31.00	03100	INTENSIVE CARE UNIT	5,095	5,095	12,921	0	607,467	31.00
43.00	04300	NURSERY	1,221	1,221	53,260	0	92,967	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,479	27,479	605,861	0	1,886,590	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	615	615	9,243	0	395,088	52.00
53.00	05300	ANESTHESIOLOGY	461	461	5,598	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,015	8,015	206,428	0	787,499	54.00
54.01	05402	NUCLEAR MEDICINE	2,098	2,098	87,552	0	111,730	54.01
57.00	05700	CT SCAN	650	650	72,240	0	149,603	57.00
60.00	06000	LABORATORY	3,909	3,909	54,771	0	918,126	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	234	234	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,170	1,170	12,640	0	417,032	65.00
66.00	06600	PHYSICAL THERAPY	10,457	10,457	0	0	1,164,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	39	39	0	0	88,482	67.00
68.00	06800	SPEECH PATHOLOGY	176	176	0	0	70,615	68.00
69.00	06900	ELECTROCARDIOLOGY	132	132	22,400	0	132,038	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,332	1,332	0	0	74,297	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,786	7,786	27,245	0	40,355	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,860	2,860	15,776	0	659,238	73.00
76.00	03020	SONOGRAPHY	535	535	44,205	0	144,577	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	1,491	1,491	9,014	0	157,691	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	16,960	16,960	121,799	0	5,141,456	90.00
91.00	09100	EMERGENCY	5,503	5,503	2,901	0	774,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	351	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	974	974	192	0	390,030	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	266,620	266,620	2,596,667	95	22,330,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,335	1,335	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	13,274	13,274	0	0	30,301	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	0	46,827	194.03
194.04	07954	RENTAL AREA/PPOS	11,027	11,027	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	1,490	0	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	2,900	2,900	4,687	0	194,917	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			1.00	1.01	2.00	2.01	4.00	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	10,189	0	115,875	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	179,802	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	4,893	0	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	64,282	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,469,898	45,843	2,736,891	95	5,325,616	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.368110	0.155318	1.045442	1.000000	0.231931	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,427	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000411	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,921,096	50,708,374				5.00
7.00	00700	OPERATION OF PLANT	0	2,671,428	175,164			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	212,760	794	262,191		8.00
9.00	00900	HOUSEKEEPING	0	713,176	3,169	0	36,336	9.00
10.00	01000	DIETARY	0	377,903	8,155	0	1,804	10.00
11.00	01100	CAFETERIA	0	856,453	2,710	0	1,439	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,134,857	3,274	0	1,082	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,880,432	4,195	0	2,187	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,174,233	25,139	170,510	13,886	30.00
31.00	03100	INTENSIVE CARE UNIT	0	860,531	5,095	13,975	1,789	31.00
43.00	04300	NURSERY	0	208,015	1,221	0	164	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,757,676	27,479	27,792	2,893	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	559,548	615	0	725	52.00
53.00	05300	ANESTHESIOLOGY	0	197,249	461	0	30	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,646,612	8,015	17,488	1,075	54.00
54.01	05402	NUCLEAR MEDICINE	0	591,062	2,098	0	65	54.01
57.00	05700	CT SCAN	0	379,738	650	3,487	65	57.00
60.00	06000	LABORATORY	0	3,445,744	3,909	131	724	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	221,497	234	0	76	63.00
65.00	06500	RESPIRATORY THERAPY	0	600,825	1,170	512	175	65.00
66.00	06600	PHYSICAL THERAPY	0	1,625,254	10,457	13,975	360	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	195,474	39	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	91,307	176	0	65	68.00
69.00	06900	ELECTROCARDIOLOGY	0	243,192	132	0	113	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	112,433	1,332	0	26	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	362,369	7,786	0	175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,964,619	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,320,428	2,860	0	724	73.00
76.00	03020	SONOGRAPHY	0	507,577	535	0	65	76.00
76.01	03040	AUDIOLOGY	0	228,438	0	0	65	76.01
76.02	03160	CARDIAC REHAB	0	228,634	1,491	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	9,914,608	16,960	0	0	90.00
91.00	09100	EMERGENCY	0	1,433,894	5,503	13,975	724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	503,667	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	898,987	974	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-10,921,096	49,120,620	146,628	261,845	30,496	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,378	1,335	0	65	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	154,793	13,274	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	72,623	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	93,988	11,027	0	5,775	194.04
194.05	07955	SPECIALTY CLINICS	0	3,244	0	346	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	657,673	2,900	0	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
194.20	07970	PARATRANSIT	0	197,824	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	310,508	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	356	0	0	0	194.24
194.27	07977	MIDTOWN	0	5,115	0	0	0	194.27
194.28	07978	PAIN CLINIC	0	80,252	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
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)		10,921,096	3,246,776	273,299	925,512	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.215371	18.535635	1.042366	25.470938	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,826,802	475,459	16,603	65,044	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.036026	2.714365	0.063324	1.790070	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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	22,241					10.00
11.00	01100	CAFETERIA	0	24,334				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,047	239,660			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,014	0	198,476,776		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,345	4,773	99,276	10,348,720	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,778	1,053	21,894	1,658,426	0	31.00
43.00	04300	NURSERY	0	300	6,245	705,985	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5	3,565	74,153	32,496,162	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	560	11,648	1,051,845	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,817,254	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,508	0	12,565,595	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	225	0	2,439,104	0	54.01
57.00	05700	CT SCAN	0	149	0	15,141,620	0	57.00
60.00	06000	LABORATORY	0	1,906	0	28,041,160	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	435,362	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	690	0	2,967,020	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,658,597	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	988,808	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	337,976	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	218	0	3,897,337	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	169	0	1,115,775	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	145	0	9,415,478	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,466,087	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	806	0	6,741,638	0	73.00
76.00	03020	SONOGRAPHY	0	204	0	5,520,036	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	474,247	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	864,393	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,640	0	6,250,947	0	90.00
91.00	09100	EMERGENCY	0	1,271	26,444	8,065,495	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	496,733	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	689	0	2,676,808	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,128	23,932	239,660	173,638,608	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	6,115,545	0	194.00
194.01	07951	CONGREGATE LIVING	4,113	83	0	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	2,737,897	0	194.02
194.03	07953	MANAGED CARE	0	80	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	468,652	0	194.05
194.08	07958	ENT	0	0	0	1,653,545	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	601,693	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	3,506,175	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	2,828,302	0	194.13
194.14	07964	HENRY	0	0	0	126,864	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	537,306	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	150,869	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	2,479,124	0	194.18

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/26/2016 11:35 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
194.19	07969	GRANVILLE CLINIC	0	0	0	369,737	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	239	0	483,931	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	2,581,439	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	34,830	0	194.28
194.30	07980	WHC-PTON	0	0	0	162,259	0	194.30
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)	656,400	1,127,793	1,516,043	2,558,573	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.513061	46.346388	6.325807	0.012891	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	135,820	64,119	84,465	165,635	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.106740	2.634955	0.352437	0.000835	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 11:35 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,290,750		6,290,750	83,766	6,374,516	30.00
31.00	03100	INTENSIVE CARE UNIT	1,491,104		1,491,104	0	1,491,104	31.00
43.00	04300	NURSERY	342,134		342,134	0	342,134	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,878,452		9,878,452	0	9,878,452	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	823,119		823,119	0	823,119	52.00
53.00	05300	ANESTHESIOLOGY	324,030		324,030	109,902	433,932	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,642,661		3,642,661	0	3,642,661	54.00
54.01	05402	NUCLEAR MEDICINE	800,774		800,774	0	800,774	54.01
57.00	05700	CT SCAN	680,959		680,959	0	680,959	57.00
60.00	06000	LABORATORY	4,728,706		4,728,706	0	4,728,706	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	281,086		281,086	0	281,086	63.00
65.00	06500	RESPIRATORY THERAPY	827,130	0	827,130	0	827,130	65.00
66.00	06600	PHYSICAL THERAPY	2,304,469	0	2,304,469	0	2,304,469	66.00
67.00	06700	OCCUPATIONAL THERAPY	251,043	0	251,043	0	251,043	67.00
68.00	06800	SPEECH PATHOLOGY	120,247	0	120,247	0	120,247	68.00
69.00	06900	ELECTROCARDIOLOGY	361,239		361,239	0	361,239	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	184,215		184,215	0	184,215	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	717,283		717,283	0	717,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,660,684		3,660,684	0	3,660,684	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,015,895		3,015,895	0	3,015,895	73.00
76.00	03020	SONOGRAPHY	709,081		709,081	0	709,081	76.00
76.01	03040	AUDIOLOGY	285,407		285,407	0	285,407	76.01
76.02	03160	CARDIAC REHAB	316,655		316,655	0	316,655	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	12,520,864		12,520,864	0	12,520,864	90.00
91.00	09100	EMERGENCY	2,207,881		2,207,881	287,464	2,495,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,903,862		1,903,862		1,903,862	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	618,545		618,545	0	618,545	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,177,097		1,177,097		1,177,097	116.00
200.00		Subtotal (see instructions)	60,465,372	0	60,465,372	481,132	60,946,504	200.00
201.00		Less Observation Beds	1,903,862		1,903,862		1,903,862	201.00
202.00		Total (see instructions)	58,561,510	0	58,561,510	481,132	59,042,642	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 11:35 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,750,763		6,750,763			30.00
31.00	03100	INTENSIVE CARE UNIT	1,653,566		1,653,566			31.00
43.00	04300	NURSERY	699,994		699,994			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,234,489	24,004,478	32,238,967	0.306413	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	920,206	122,088	1,042,294	0.789719	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,959,025	3,808,874	5,767,899	0.056178	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,188,414	11,298,766	12,487,180	0.291712	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	125,363	2,299,626	2,424,989	0.330218	0.000000	54.01
57.00	05700	CT SCAN	1,959,746	13,098,821	15,058,567	0.045221	0.000000	57.00
60.00	06000	LABORATORY	5,590,352	22,309,193	27,899,545	0.169490	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	257,565	176,331	433,896	0.647819	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,204,971	753,757	2,958,728	0.279556	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	829,135	7,783,371	8,612,506	0.267572	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,938	863,233	984,171	0.255081	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	46,770	290,305	337,075	0.356737	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,493,090	2,392,552	3,885,642	0.092968	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,380	1,101,880	1,107,260	0.166370	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,946,715	3,443,247	9,389,962	0.076388	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,116,168	349,919	4,466,087	0.819662	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,867,120	3,826,038	6,693,158	0.450594	0.000000	73.00
76.00	03020	SONOGRAPHY	808,065	4,681,078	5,489,143	0.129179	0.000000	76.00
76.01	03040	AUDIOLOGY	0	474,247	474,247	0.601811	0.000000	76.01
76.02	03160	CARDIAC REHAB	9,245	850,187	859,432	0.368447	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	23,000	6,179,148	6,202,148	2.018795	0.000000	90.00
91.00	09100	EMERGENCY	1,254,872	6,774,347	8,029,219	0.274981	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	882,849	2,677,403	3,560,252	0.534755	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	495,091	495,091	1.249356	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	2,676,418	2,676,418			116.00
200.00		Subtotal (see instructions)	49,947,801	122,730,398	172,678,199			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	49,947,801	122,730,398	172,678,199			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 11:35 am

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		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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.306413	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.789719	52.00
53.00	05300	ANESTHESIOLOGY	0.075232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.291712	54.00
54.01	05402	NUCLEAR MEDICINE	0.330218	54.01
57.00	05700	CT SCAN	0.045221	57.00
60.00	06000	LABORATORY	0.169490	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.647819	63.00
65.00	06500	RESPIRATORY THERAPY	0.279556	65.00
66.00	06600	PHYSICAL THERAPY	0.267572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.255081	67.00
68.00	06800	SPEECH PATHOLOGY	0.356737	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092968	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166370	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.819662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450594	73.00
76.00	03020	SONOGRAPHY	0.129179	76.00
76.01	03040	AUDIOLOGY	0.601811	76.01
76.02	03160	CARDIAC REHAB	0.368447	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	2.018795	90.00
91.00	09100	EMERGENCY	0.310783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.534755	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	1.249356	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,290,750		6,290,750	83,766	6,374,516	30.00
31.00	03100	INTENSIVE CARE UNIT	1,491,104		1,491,104	0	1,491,104	31.00
43.00	04300	NURSERY	342,134		342,134	0	342,134	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,878,452		9,878,452	0	9,878,452	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	823,119		823,119	0	823,119	52.00
53.00	05300	ANESTHESIOLOGY	324,030		324,030	109,902	433,932	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,642,661		3,642,661	0	3,642,661	54.00
54.01	05402	NUCLEAR MEDICINE	800,774		800,774	0	800,774	54.01
57.00	05700	CT SCAN	680,959		680,959	0	680,959	57.00
60.00	06000	LABORATORY	4,728,706		4,728,706	0	4,728,706	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	281,086		281,086	0	281,086	63.00
65.00	06500	RESPIRATORY THERAPY	827,130	0	827,130	0	827,130	65.00
66.00	06600	PHYSICAL THERAPY	2,304,469	0	2,304,469	0	2,304,469	66.00
67.00	06700	OCCUPATIONAL THERAPY	251,043	0	251,043	0	251,043	67.00
68.00	06800	SPEECH PATHOLOGY	120,247	0	120,247	0	120,247	68.00
69.00	06900	ELECTROCARDIOLOGY	361,239		361,239	0	361,239	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	184,215		184,215	0	184,215	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	717,283		717,283	0	717,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,660,684		3,660,684	0	3,660,684	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,015,895		3,015,895	0	3,015,895	73.00
76.00	03020	SONOGRAPHY	709,081		709,081	0	709,081	76.00
76.01	03040	AUDIOLOGY	285,407		285,407	0	285,407	76.01
76.02	03160	CARDIAC REHAB	316,655		316,655	0	316,655	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	12,520,864		12,520,864	0	12,520,864	90.00
91.00	09100	EMERGENCY	2,207,881		2,207,881	287,464	2,495,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,903,862		1,903,862		1,903,862	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	618,545		618,545	0	618,545	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,177,097		1,177,097		1,177,097	116.00
200.00		Subtotal (see instructions)	60,465,372	0	60,465,372	481,132	60,946,504	200.00
201.00		Less Observation Beds	1,903,862		1,903,862		1,903,862	201.00
202.00		Total (see instructions)	58,561,510	0	58,561,510	481,132	59,042,642	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,750,763		6,750,763			30.00
31.00	03100	INTENSIVE CARE UNIT	1,653,566		1,653,566			31.00
43.00	04300	NURSERY	699,994		699,994			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,234,489	24,004,478	32,238,967	0.306413	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	920,206	122,088	1,042,294	0.789719	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,959,025	3,808,874	5,767,899	0.056178	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,188,414	11,298,766	12,487,180	0.291712	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	125,363	2,299,626	2,424,989	0.330218	0.000000	54.01
57.00	05700	CT SCAN	1,959,746	13,098,821	15,058,567	0.045221	0.000000	57.00
60.00	06000	LABORATORY	5,590,352	22,309,193	27,899,545	0.169490	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	257,565	176,331	433,896	0.647819	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,204,971	753,757	2,958,728	0.279556	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	829,135	7,783,371	8,612,506	0.267572	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	120,938	863,233	984,171	0.255081	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	46,770	290,305	337,075	0.356737	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,493,090	2,392,552	3,885,642	0.092968	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,380	1,101,880	1,107,260	0.166370	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,946,715	3,443,247	9,389,962	0.076388	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,116,168	349,919	4,466,087	0.819662	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,867,120	3,826,038	6,693,158	0.450594	0.000000	73.00
76.00	03020	SONOGRAPHY	808,065	4,681,078	5,489,143	0.129179	0.000000	76.00
76.01	03040	AUDIOLOGY	0	474,247	474,247	0.601811	0.000000	76.01
76.02	03160	CARDIAC REHAB	9,245	850,187	859,432	0.368447	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	23,000	6,179,148	6,202,148	2.018795	0.000000	90.00
91.00	09100	EMERGENCY	1,254,872	6,774,347	8,029,219	0.274981	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	882,849	2,677,403	3,560,252	0.534755	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	495,091	495,091	1.249356	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	2,676,418	2,676,418			116.00
200.00		Subtotal (see instructions)	49,947,801	122,730,398	172,678,199			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	49,947,801	122,730,398	172,678,199			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | PPS

		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
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.306413	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.789719	52.00
53.00	05300	ANESTHESIOLOGY	0.075232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.291712	54.00
54.01	05402	NUCLEAR MEDICINE	0.330218	54.01
57.00	05700	CT SCAN	0.045221	57.00
60.00	06000	LABORATORY	0.169490	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.647819	63.00
65.00	06500	RESPIRATORY THERAPY	0.279556	65.00
66.00	06600	PHYSICAL THERAPY	0.267572	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.255081	67.00
68.00	06800	SPEECH PATHOLOGY	0.356737	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092968	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166370	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.819662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450594	73.00
76.00	03020	SONOGRAPHY	0.129179	76.00
76.01	03040	AUDIOLOGY	0.601811	76.01
76.02	03160	CARDIAC REHAB	0.368447	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	2.018795	90.00
91.00	09100	EMERGENCY	0.310783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.534755	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	1.249356	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,878,452	1,405,359	8,473,093	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	823,119	44,651	778,468	0	0	52.00
53.00	05300	ANESTHESIOLOGY	324,030	51,680	272,350	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,642,661	800,468	2,842,193	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	800,774	139,194	661,580	0	0	54.01
57.00	05700	CT SCAN	680,959	109,941	571,018	0	0	57.00
60.00	06000	LABORATORY	4,728,706	255,441	4,473,265	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	281,086	11,109	269,977	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	827,130	61,860	765,270	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,304,469	200,076	2,104,393	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	251,043	8,342	242,701	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	120,247	5,694	114,553	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	361,239	37,747	323,492	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	184,215	20,475	163,740	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	717,283	137,609	579,674	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,660,684	110,532	3,550,152	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,015,895	158,505	2,857,390	0	0	73.00
76.00	03020	SONOGRAPHY	709,081	75,834	633,247	0	0	76.00
76.01	03040	AUDIOLOGY	285,407	8,742	276,665	0	0	76.01
76.02	03160	CARDIAC REHAB	316,655	35,204	281,451	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	12,520,864	697,365	11,823,499	0	0	90.00
91.00	09100	EMERGENCY	2,207,881	151,857	2,056,024	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,903,862	211,982	1,691,880	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	618,545	18,560	599,985	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,177,097	83,819	1,093,278	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	52,341,384	4,842,046	47,499,338	0	0	200.00
201.00		Less Observation Beds	1,903,862	211,982	1,691,880	0	0	201.00
202.00		Total (line 200 minus line 201)	50,437,522	4,630,064	45,807,458	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,878,452	32,238,967	0.306413		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	823,119	1,042,294	0.789719		52.00
53.00	05300	ANESTHESIOLOGY	324,030	5,767,899	0.056178		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,642,661	12,487,180	0.291712		54.00
54.01	05402	NUCLEAR MEDICINE	800,774	2,424,989	0.330218		54.01
57.00	05700	CT SCAN	680,959	15,058,567	0.045221		57.00
60.00	06000	LABORATORY	4,728,706	27,899,545	0.169490		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	281,086	433,896	0.647819		63.00
65.00	06500	RESPIRATORY THERAPY	827,130	2,958,728	0.279556		65.00
66.00	06600	PHYSICAL THERAPY	2,304,469	8,612,506	0.267572		66.00
67.00	06700	OCCUPATIONAL THERAPY	251,043	984,171	0.255081		67.00
68.00	06800	SPEECH PATHOLOGY	120,247	337,075	0.356737		68.00
69.00	06900	ELECTROCARDIOLOGY	361,239	3,885,642	0.092968		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	184,215	1,107,260	0.166370		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	717,283	9,389,962	0.076388		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,660,684	4,466,087	0.819662		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,015,895	6,693,158	0.450594		73.00
76.00	03020	SONOGRAPHY	709,081	5,489,143	0.129179		76.00
76.01	03040	AUDIOLOGY	285,407	474,247	0.601811		76.01
76.02	03160	CARDIAC REHAB	316,655	859,432	0.368447		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
90.00	09000	CLINIC	12,520,864	6,202,148	2.018795		90.00
91.00	09100	EMERGENCY	2,207,881	8,029,219	0.274981		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,903,862	3,560,252	0.534755		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	618,545	495,091	1.249356		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,177,097	2,676,418	0.439803		116.00
200.00		Subtotal (sum of lines 50 thru 199)	52,341,384	163,573,876			200.00
201.00		Less Observation Beds	1,903,862	0			201.00
202.00		Total (line 200 minus line 201)	50,437,522	163,573,876			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/26/2016 11:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	706,607	3,135	703,472	7,450	94.43	30.00
31.00	INTENSIVE CARE UNIT	151,988		151,988	786	193.37	31.00
43.00	NURSERY	80,807		80,807	706	114.46	43.00
200.00	Total (lines 30-199)	939,402		936,267	8,942		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	3,163	298,682				30.00
31.00	INTENSIVE CARE UNIT	545	105,387				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	3,708	404,069				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/26/2016 11:35 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	1,405,359	32,238,967	0.043592	3,904,368	170,199	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,651	1,042,294	0.042839	3,354	144	52.00
53.00	05300	ANESTHESIOLOGY	51,680	5,767,899	0.008960	949,209	8,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,468	12,487,180	0.064103	1,071,733	68,701	54.00
54.01	05402	NUCLEAR MEDICINE	139,194	2,424,989	0.057400	94,391	5,418	54.01
57.00	05700	CT SCAN	109,941	15,058,567	0.007301	1,459,661	10,657	57.00
60.00	06000	LABORATORY	255,441	27,899,545	0.009156	3,935,743	36,036	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,109	433,896	0.025603	183,332	4,694	63.00
65.00	06500	RESPIRATORY THERAPY	61,860	2,958,728	0.020908	1,490,802	31,170	65.00
66.00	06600	PHYSICAL THERAPY	200,076	8,612,506	0.023231	511,380	11,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,342	984,171	0.008476	66,811	566	67.00
68.00	06800	SPEECH PATHOLOGY	5,694	337,075	0.016892	39,424	666	68.00
69.00	06900	ELECTROCARDIOLOGY	37,747	3,885,642	0.009714	1,261,858	12,258	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,475	1,107,260	0.018492	4,908	91	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	137,609	9,389,962	0.014655	4,300,931	63,030	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,532	4,466,087	0.024749	2,102,864	52,044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,505	6,693,158	0.023682	1,755,880	41,583	73.00
76.00	03020	SONOGRAPHY	75,834	5,489,143	0.013815	500,916	6,920	76.00
76.01	03040	AUDIOLOGY	8,742	474,247	0.018433	0	0	76.01
76.02	03160	CARDIAC REHAB	35,204	859,432	0.040962	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	697,365	6,202,148	0.112439	17,649	1,984	90.00
91.00	09100	EMERGENCY	151,857	8,029,219	0.018913	1,077,856	20,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	211,982	3,560,252	0.059541	171,808	10,230	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	4,739,667	160,402,367		24,904,878	557,161	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/26/2016 11:35 am

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	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)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,450	0.00	3,163	0		30.00
31.00	03100	INTENSIVE CARE UNIT	786	0.00	545	0		31.00
43.00	04300	NURSERY	706	0.00	0	0		43.00
200.00		Total (lines 30-199)	8,942		3,708	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 11:35 am

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		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
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
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 11:35 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)	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	32,238,967	0.000000	0.000000	3,904,368	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,042,294	0.000000	0.000000	3,354	52.00
53.00	05300	ANESTHESIOLOGY	0	5,767,899	0.000000	0.000000	949,209	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,487,180	0.000000	0.000000	1,071,733	54.00
54.01	05402	NUCLEAR MEDICINE	0	2,424,989	0.000000	0.000000	94,391	54.01
57.00	05700	CT SCAN	0	15,058,567	0.000000	0.000000	1,459,661	57.00
60.00	06000	LABORATORY	0	27,899,545	0.000000	0.000000	3,935,743	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	433,896	0.000000	0.000000	183,332	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,958,728	0.000000	0.000000	1,490,802	65.00
66.00	06600	PHYSICAL THERAPY	0	8,612,506	0.000000	0.000000	511,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	984,171	0.000000	0.000000	66,811	67.00
68.00	06800	SPEECH PATHOLOGY	0	337,075	0.000000	0.000000	39,424	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,885,642	0.000000	0.000000	1,261,858	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,107,260	0.000000	0.000000	4,908	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,389,962	0.000000	0.000000	4,300,931	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,466,087	0.000000	0.000000	2,102,864	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,693,158	0.000000	0.000000	1,755,880	73.00
76.00	03020	SONOGRAPHY	0	5,489,143	0.000000	0.000000	500,916	76.00
76.01	03040	AUDIOLOGY	0	474,247	0.000000	0.000000	0	76.01
76.02	03160	CARDIAC REHAB	0	859,432	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	6,202,148	0.000000	0.000000	17,649	90.00
91.00	09100	EMERGENCY	0	8,029,219	0.000000	0.000000	1,077,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,560,252	0.000000	0.000000	171,808	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	160,402,367			24,904,878	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 11:35 am

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,814,556	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	288	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,133,036	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,295,860	0		54.00
54.01	05402	NUCLEAR MEDICINE	0	1,115,453	0		54.01
57.00	05700	CT SCAN	0	4,730,750	0		57.00
60.00	06000	LABORATORY	0	3,738,406	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	70,805	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	391,972	0		65.00
66.00	06600	PHYSICAL THERAPY	0	6,913	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,056,172	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	99,654	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,685,449	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	178,766	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,094,904	0		73.00
76.00	03020	SONOGRAPHY	0	1,083,020	0		76.00
76.01	03040	AUDIOLOGY	0	76,863	0		76.01
76.02	03160	CARDIAC REHAB	0	59,040	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	1,275,246	0		90.00
91.00	09100	EMERGENCY	0	1,929,445	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	646,351	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	32,482,949	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/26/2016 11:35 am

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.306413	6,814,556	0	0	2,088,069	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.789719	288	0	0	227	52.00
53.00	05300	ANESTHESIOLOGY	0.056178	1,133,036	0	0	63,652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.291712	4,295,860	0	0	1,253,154	54.00
54.01	05402	NUCLEAR MEDICINE	0.330218	1,115,453	0	0	368,343	54.01
57.00	05700	CT SCAN	0.045221	4,730,750	0	0	213,929	57.00
60.00	06000	LABORATORY	0.169490	3,738,406	931	0	633,622	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.647819	70,805	0	0	45,869	63.00
65.00	06500	RESPIRATORY THERAPY	0.279556	391,972	0	0	109,578	65.00
66.00	06600	PHYSICAL THERAPY	0.267572	6,913	0	0	1,850	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.255081	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.356737	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092968	1,056,172	0	0	98,190	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166370	99,654	0	0	16,579	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076388	1,685,449	0	0	128,748	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.819662	178,766	0	0	146,528	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450594	2,094,904	540	44,170	943,951	73.00
76.00	03020	SONOGRAPHY	0.129179	1,083,020	0	0	139,903	76.00
76.01	03040	AUDIOLOGY	0.601811	76,863	0	0	46,257	76.01
76.02	03160	CARDIAC REHAB	0.368447	59,040	0	0	21,753	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.018795	1,275,246	0	0	2,574,460	90.00
91.00	09100	EMERGENCY	0.274981	1,929,445	0	0	530,561	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.534755	646,351	0	0	345,639	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.249356		0			95.00
200.00		Subtotal (see instructions)		32,482,949	1,471	44,170	9,770,862	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		32,482,949	1,471	44,170	9,770,862	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/26/2016 11:35 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
54.01	05402	NUCLEAR MEDICINE	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	158	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	243	19,903		73.00
76.00	03020	SONOGRAPHY	0	0		76.00
76.01	03040	AUDIOLOGY	0	0		76.01
76.02	03160	CARDIAC REHAB	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	401	19,903		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	401	19,903		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/26/2016 11:35 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	706,607	3,111	703,496	7,450	94.43	30.00
31.00	INTENSIVE CARE UNIT	151,988		151,988	786	193.37	31.00
43.00	NURSERY	80,807		80,807	706	114.46	43.00
200.00	Total (lines 30-199)	939,402		936,291	8,942		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	546	51,559				30.00
31.00	INTENSIVE CARE UNIT	61	11,796				31.00
43.00	NURSERY	379	43,380				43.00
200.00	Total (lines 30-199)	986	106,735				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/26/2016 11:35 am

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,405,359	32,238,967	0.043592	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,651	1,042,294	0.042839	0	0	52.00
53.00	05300	ANESTHESIOLOGY	51,680	5,767,899	0.008960	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800,468	12,487,180	0.064103	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	139,194	2,424,989	0.057400	0	0	54.01
57.00	05700	CT SCAN	109,941	15,058,567	0.007301	0	0	57.00
60.00	06000	LABORATORY	255,441	27,899,545	0.009156	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,109	433,896	0.025603	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	61,860	2,958,728	0.020908	0	0	65.00
66.00	06600	PHYSICAL THERAPY	200,076	8,612,506	0.023231	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,342	984,171	0.008476	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,694	337,075	0.016892	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37,747	3,885,642	0.009714	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,475	1,107,260	0.018492	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	137,609	9,389,962	0.014655	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	110,532	4,466,087	0.024749	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,505	6,693,158	0.023682	0	0	73.00
76.00	03020	SONOGRAPHY	75,834	5,489,143	0.013815	0	0	76.00
76.01	03040	AUDIOLOGY	8,742	474,247	0.018433	0	0	76.01
76.02	03160	CARDIAC REHAB	35,204	859,432	0.040962	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	697,365	6,202,148	0.112439	0	0	90.00
91.00	09100	EMERGENCY	151,857	8,029,219	0.018913	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	211,982	3,560,252	0.059541	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	4,739,667	160,402,367		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	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)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,450	0.00	546	0		30.00
31.00	03100	INTENSIVE CARE UNIT	786	0.00	61	0		31.00
43.00	04300	NURSERY	706	0.00	379	0		43.00
200.00		Total (lines 30-199)	8,942		986	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | 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
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
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | 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	32,238,967	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,042,294	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,767,899	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,487,180	0.000000	0.000000	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	2,424,989	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	15,058,567	0.000000	0.000000	0	57.00
60.00	06000	LABORATORY	0	27,899,545	0.000000	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	433,896	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,958,728	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,612,506	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	984,171	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	337,075	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,885,642	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,107,260	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,389,962	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,466,087	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,693,158	0.000000	0.000000	0	73.00
76.00	03020	SONOGRAPHY	0	5,489,143	0.000000	0.000000	0	76.00
76.01	03040	AUDIOLOGY	0	474,247	0.000000	0.000000	0	76.01
76.02	03160	CARDIAC REHAB	0	859,432	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	6,202,148	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	8,029,219	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,560,252	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	160,402,367			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0		54.01
57.00	05700	CT SCAN	0	0	0		57.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	SONOGRAPHY	0	0	0		76.00
76.01	03040	AUDIOLOGY	0	0	0		76.01
76.02	03160	CARDIAC REHAB	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 11:35 am
	Title XVIII	Hospital	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)	7,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,450	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.	2,078	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,137	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	35	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)	90	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)	3,163	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)	29	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)	82	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	222.37	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	227.71	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)	6,374,516	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)	7,783	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)	20,494	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)	28,277	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,346,239	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	8,278,206	28.00
29.00	Private room charges (excluding swing-bed charges)	3,279,090	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,999,116	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.766620	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,578.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,593.60	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)	6,346,239	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)	851.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,694,370	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,694,370	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/26/2016 11:35 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,491,104	786	1,897.08	545	1,033,909	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)	6,539,446	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,267,725	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)	404,069	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	557,161	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	961,230	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,306,495	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)	6,449	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	18,672	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	25,121	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)	2,235	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	851.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,903,862	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 11:35 am
	Title XVIII	Hospital	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	706,607	6,346,239	0.111343	1,903,862	211,982	90.00
91.00	Nursing School cost	0	6,346,239	0.000000	1,903,862	0	91.00
92.00	Allied health cost	0	6,346,239	0.000000	1,903,862	0	92.00
93.00	All other Medical Education	0	6,346,239	0.000000	1,903,862	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 11:35 am
	Title XIX	Hospital	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)	7,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,450	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,215	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	74	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)	51	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)	546	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)	706	15.00
16.00	Nursery days (title V or XIX only)	379	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	222.37	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	227.71	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)	6,374,516	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)	16,455	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)	11,613	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)	28,068	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,346,448	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)	6,346,448	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)	851.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	465,121	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)	465,121	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/26/2016 11:35 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	342,134	706	484.61	379	183,667	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,491,104	786	1,897.08	61	115,722	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	764,510	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)	106,735	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	106,735	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	657,775	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)	2,235	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	851.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,903,929	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/26/2016 11:35 am
	Title XIX	Hospital	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	706,607	6,346,448	0.111339	1,903,929	211,982	90.00
91.00	Nursing School cost	0	6,346,448	0.000000	1,903,929	0	91.00
92.00	Allied health cost	0	6,346,448	0.000000	1,903,929	0	92.00
93.00	All other Medical Education	0	6,346,448	0.000000	1,903,929	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/26/2016 11:35 am

Title XVIII | Hospital | 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		3,829,020		30.00
31.00	03100	INTENSIVE CARE UNIT		1,188,250		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.306413	3,904,368	1,196,349	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.789719	3,354	2,649	52.00
53.00	05300	ANESTHESIOLOGY	0.075232	949,209	71,411	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.291712	1,071,733	312,637	54.00
54.01	05402	NUCLEAR MEDICINE	0.330218	94,391	31,170	54.01
57.00	05700	CT SCAN	0.045221	1,459,661	66,007	57.00
60.00	06000	LABORATORY	0.169490	3,935,743	667,069	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.647819	183,332	118,766	63.00
65.00	06500	RESPIRATORY THERAPY	0.279556	1,490,802	416,763	65.00
66.00	06600	PHYSICAL THERAPY	0.267572	511,380	136,831	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.255081	66,811	17,042	67.00
68.00	06800	SPEECH PATHOLOGY	0.356737	39,424	14,064	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092968	1,261,858	117,312	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166370	4,908	817	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076388	4,300,931	328,540	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.819662	2,102,864	1,723,638	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450594	1,755,880	791,189	73.00
76.00	03020	SONOGRAPHY	0.129179	500,916	64,708	76.00
76.01	03040	AUDIOLOGY	0.601811	0	0	76.01
76.02	03160	CARDIAC REHAB	0.368447	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.018795	17,649	35,630	90.00
91.00	09100	EMERGENCY	0.310783	1,077,856	334,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.534755	171,808	91,875	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		24,904,878	6,539,446	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)		24,904,878		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140143 | Component CCN: 14U143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/26/2016 11:35 am

Title XVIII | Swing Beds - SNF | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.306413	4,638	1,421	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.789719	10	8	52.00
53.00	05300	ANESTHESIOLOGY	0.056178	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.291712	2,134	623	54.00
54.01	05402	NUCLEAR MEDICINE	0.330218	0	0	54.01
57.00	05700	CT SCAN	0.045221	0	0	57.00
60.00	06000	LABORATORY	0.169490	32,077	5,437	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.647819	2,824	1,829	63.00
65.00	06500	RESPIRATORY THERAPY	0.279556	25,275	7,066	65.00
66.00	06600	PHYSICAL THERAPY	0.267572	16,844	4,507	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.255081	1,146	292	67.00
68.00	06800	SPEECH PATHOLOGY	0.356737	1,819	649	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092968	898	83	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.166370	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.076388	79,286	6,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.819662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.450594	35,312	15,911	73.00
76.00	03020	SONOGRAPHY	0.129179	0	0	76.00
76.01	03040	AUDIOLOGY	0.601811	0	0	76.01
76.02	03160	CARDIAC REHAB	0.368447	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.018795	4,374	8,830	90.00
91.00	09100	EMERGENCY	0.274981	12	3	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.534755	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		206,649	52,715	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)		206,649		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 11:35 am
	Title XVIII	Hospital	PPS

			before 1/1	on/after 1/1		
		0	1.00	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)		6,990,664			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)		29,742			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)		59.53			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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/26/2016 11:35 am

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.10			30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.16			31.00
32.00	Sum of lines 30 and 31		16.26			32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.32			33.00
34.00	Disproportionate share adjustment (see instructions)		58,023			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		0.000028149	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		215,274	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		215,274	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		215,274			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 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)		7,293,703			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		8,438,283			48.00
49.00	Total payment for inpatient operating costs (see instructions)		8,152,138			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		553,892			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 intructions)		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)		8,706,030			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,706,030			61.00
62.00	Deductibles billed to program beneficiaries		958,049			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 11:35 am
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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		3,233			63.00
64.00	Allowable bad debts (see instructions)		134,424			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		87,376			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		115,751			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,832,124			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		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)		2,550			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-2,060			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		20,232			70.93
70.94	HRR adjustment amount (see instructions)		-16,347			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,836,499			71.00
71.01	Sequestration adjustment (see instructions)		156,730			71.01
72.00	Interim payments		7,540,780			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)		138,989			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		129,157			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: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/26/2016 11:35 am
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		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			858,435	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)			1.00297	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			2,550	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)			0.9976	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			-2,060	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2016 11:35 am

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		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	6,272,585	6,272,585	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	6,990,664	0	0	6,811,246	6,811,246	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	29,742	0	0	29,742	29,742	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	0.0332	0.0332	0.0332	0.0332		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	58,023	0	0	58,023	58,023	11.00
11.01	Uncompensated care payments	36.00	215,274	0	0	273,155	273,155	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	7,293,703	0	0	7,293,703	7,293,703	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	8,438,283	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,152,138	0	0	8,152,138	8,152,138	15.00
16.00	Payment for inpatient program capital	50.00	553,892	0	0	553,892	553,892	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition 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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/26/2016 11:35 am

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		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	
19.00	SUBTOTAL			0	0	8,706,030	8,706,030	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	550,279	0	0	550,279	550,279	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	3,613	0	0	3,613	3,613	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		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		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	553,892	0	0	553,892	553,892	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	0.071429		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				621,863	621,863	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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2016 11:35 am

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		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	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,990,664		6,811,246	6,811,246	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	29,742	0	29,742	29,742	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	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	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	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	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	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	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0332	0.0332	0.0332		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	58,023	0	58,023	58,023	11.00
11.01	Uncompensated care payments	36.00	215,274	0	273,155	273,155	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	12.00
13.00	Subtotal (see instructions)	47.00	7,293,703	0	7,293,703	7,293,703	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	8,438,283	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,152,138	0	8,152,138	8,152,138	15.00
16.00	Payment for inpatient program capital	50.00	553,892	0	553,892	553,892	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	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	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	8,706,030	8,706,030	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2016 11:35 am

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		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	550,279	0	550,279	550,279	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	3,613	0	3,613	3,613	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	553,892	0	553,892	553,892	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	621,863		621,863	621,863	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	20,232	0	20,232	20,232	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	2,550	0	2,550	2,550	30.01
31.00	HRR adjustment (see instructions)	70.94	-16,347	0	-16,347	-16,347	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-2,060	0	-2,060	-2,060	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	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/26/2016 11:35 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	20,304	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,770,862	2.00
3.00	PPS payments	7,372,938	3.00
4.00	Outlier payment (see instructions)	36,215	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.799	5.00
6.00	Line 2 times line 5	7,806,919	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	94.90	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)	20,304	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	45,641	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)	45,641	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	45,641	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	25,337	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)	20,304	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)	7,409,153	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,658,388	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)	5,771,069	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)	5,771,069	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	5,771,069	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)	196,705	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	127,858	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	155,729	36.00
37.00	Subtotal (see instructions)	5,898,927	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,898,927	40.00
40.01	Sequestration adjustment (see instructions)	117,979	40.01
41.00	Interim payments	5,790,256	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-9,308	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part I Date/Time Prepared: 2/26/2016 11:35 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		6,768,412		5,790,256	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	09/22/2015	772,368		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)		772,368		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)		7,540,780		5,790,256	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		138,989		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		9,308	6.02
7.00	Total Medicare program liability (see instructions)		7,679,769		5,780,948	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: 140143 | Component CCN: 14U143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2016 11:35 am

Title XVIII | Swing Beds - SNF | 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		33,547		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)		33,547		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		33,547		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: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/26/2016 11:35 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	1,957	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,708	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	514	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,001	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	172,678,199	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,764,611	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)	768,233	8.00
9.00	Sequestration adjustment amount (see instructions)	15,365	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	752,868	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	752,868	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 140143 Component CCN: 14U143	Period: From 10/01/2014 To 09/30/2015	Worksheet E-2 Date/Time Prepared: 2/26/2016 11:35 am
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	39,043	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	111	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	39,043	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	39,043	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	39,043	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,811	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	34,232	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	65	0	18.00
19.00	Total (see instructions)	34,232	0	19.00
19.01	Sequestration adjustment (see instructions)	685	0	19.01
20.00	Interim payments	33,547	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/26/2016 11:35 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	2,884,147	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	15,003,518	0	0	0	4.00
5.00	Other receivable	187,925	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,329,000	0	0	0	6.00
7.00	Inventory	1,970,560	0	0	0	7.00
8.00	Prepaid expenses	596,252	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,313,402	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,762,328	0	0	0	12.00
13.00	Land improvements	2,600,159	0	0	0	13.00
14.00	Accumulated depreciation	-1,984,401	0	0	0	14.00
15.00	Buildings	58,275,596	0	0	0	15.00
16.00	Accumulated depreciation	-31,762,716	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	25,384,633	0	0	0	23.00
24.00	Accumulated depreciation	-18,793,080	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	3,890,517	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	40,373,036	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	24,449,871	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	2,072,076	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,521,947	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	84,208,385	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,435,334	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,328,491	0	0	0	38.00
39.00	Payroll taxes payable	226,218	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,465,984	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	190,162	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,646,189	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	18,087,667	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	1,155,339	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	19,243,006	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	31,889,195	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	52,319,190				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)	52,319,190	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	84,208,385	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/26/2016 11:35 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		49,383,529		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,218,940				2.00
3.00	Total (sum of line 1 and line 2)		52,602,469		0		3.00
4.00	CONTRIBUTIONS	59,549		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	3,450		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)		62,999		0		10.00
11.00	Subtotal (line 3 plus line 10)		52,665,468		0		11.00
12.00	EQUITY TRANSFER	50,812		0		0	12.00
13.00	CHANGE IN FOUNDATION INTEREST	295,466		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)		346,278		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		52,319,190		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	CONTRIBUTIONS		0			4.00
5.00	RESTRICTED CONTRIBUTIONS		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	EQUITY TRANSFER		0			12.00
13.00	CHANGE IN FOUNDATION INTEREST		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: 140143 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2016 11:35 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,278,206		8,278,206	1.00
2.00	SUBPROVIDER - IPF				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)	8,278,206		8,278,206	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,015,635		3,015,635	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)	3,015,635		3,015,635	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,293,841		11,293,841	17.00
18.00	Ancillary services	40,676,197	119,797,546	160,473,743	18.00
19.00	Outpatient services	0	24,362,194	24,362,194	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				22.00
23.00	AMBULANCE SERVICES	0	496,733	496,733	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,676,808	2,676,808	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,970,038	147,333,281	199,303,319	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		74,544,937		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)		74,544,937		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet G-3 Date/Time Prepared: 2/26/2016 11:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	199,303,319	1.00
2.00	Less contractual allowances and discounts on patients' accounts	122,716,174	2.00
3.00	Net patient revenues (line 1 minus line 2)	76,587,145	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,544,937	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,042,208	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	187,917	14.00
15.00	Revenue from rental of living quarters	75,788	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	341,159	17.00
18.00	Revenue from sale of medical records and abstracts	2,173	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	126,195	22.00
23.00	Governmental appropriations	0	23.00
24.00	LOSS ON DISPOSAL OF EQUIPMENT	-28,192	24.00
24.01	EMR REVENUE	494,683	24.01
24.02	OTHER	0	24.02
24.03	OTHER REVENUE	43,118	24.03
24.04	PARATRANSIT	193,813	24.04
24.05	OUTSIDE REHABILITATION SERVICES	26,326	24.05
24.06	CONTRIBUTIONS SPENT FOR OPERATIONS	315,408	24.06
24.07	INVESTMENT INCOME	-553,488	24.07
25.00	Total other income (sum of lines 6-24)	1,224,900	25.00
26.00	Total (line 5 plus line 25)	3,267,108	26.00
27.00	NET RENTAL LOSS	23,981	27.00
27.01	OTHER	0	27.01
27.02	CHANGE IN EQUITY GAINS AND LOSSES	24,138	27.02
27.03	MISCELLANEOUS	49	27.03
27.04		0	27.04
27.05		0	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	48,168	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,218,940	29.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K | Date/Time Prepared: 2/26/2016 11:35 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	0	0	0	0	8,895	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	12,000	9.00
10.00	Nursing Care	316,039	0	19,561	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	47,178	0	9,215	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	26,813	0	9,655	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	8,333	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	19,041	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	287,219	36,075	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)	390,030	0	38,431	287,219	84,344	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K | Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	8,895	0	8,895	0	8,895	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	12,000	0	12,000	0	12,000	9.00
10.00	Nursing Care	335,600	0	335,600	0	335,600	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	56,393	0	56,393	0	56,393	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	36,468	0	36,468	0	36,468	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	8,333	0	8,333	0	8,333	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	19,041	0	19,041	0	19,041	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	323,294	0	323,294	0	323,294	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)	800,024	0	800,024	0	800,024	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES | Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-1 Date/Time Prepared: 2/26/2016 11:35 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	316,039	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	47,178	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	47,178	0	316,039	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140143 Hospice CCN: 141595

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

Worksheet K-1

Date/Time Prepared: 2/26/2016 11:35 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	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	316,039		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	47,178		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		26,813	0	26,813		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	26,813	0	390,030		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-3 Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-3 Date/Time Prepared: 2/26/2016 11:35 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	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		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	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	287,219	287,219		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	287,219	287,219		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part I Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	8,895	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	12,000	0	0	0	0	9.00
10.00	Nursing Care	335,600	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	56,393	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	36,468	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	8,333	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	19,041	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	323,294	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)	800,024	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part I Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	8,895	8,895			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	12,000	135	12,135		9.00
10.00	Nursing Care	0	335,600	3,773	339,373		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	56,393	634	57,027		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	36,468	410	36,878		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	8,333	94	8,427		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	19,041	214	19,255		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	323,294	3,635	326,929		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	800,024		800,024		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part II Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	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: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part II Date/Time Prepared: 2/26/2016 11:35 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	-8,895	791,129		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	12,000		9.00
10.00	Nursing Care	0	335,600		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	56,393		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	36,468		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	8,333		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	19,041		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	323,294		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)		8,895		39.00
40.00	Unit Cost Multiplier		0.011243		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143 Hospice CCN: 141595

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

Worksheet K-5 Part I Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
		0	1.00	1.01	2.00	2.01	
1.00	Administrative and General		8,151	151	201	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	12,135	0	0	0	0	4.00
5.00	Nursing Care	339,373	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	57,027	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	36,878	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	8,427	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	19,255	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	326,929	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)	800,024	8,151	151	201	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143
Hospice CCN: 141595

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

Worksheet K-5
Part I
Date/Time Prepared:
2/26/2016 11:35 am

Hospice I

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
1.00	Administrative and General	0	8,503	1,831	18,054	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	12,135	2,614	0	0	4.00
5.00	Nursing Care	73,299	412,672	88,877	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	10,942	67,969	14,639	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	6,219	43,097	9,282	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	8,427	1,815	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	19,255	4,147	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	326,929	70,411	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	90,460	898,987	193,616	18,054	0	34.00
35.00	Unit Cost Multiplier (see instructions)		0.000000				35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS | Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-5 Part I Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
		9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	0	0	0	34,507	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	22,809	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	4,703	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	4,421	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	31,933	0	34,507	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143 Hospice CCN: 141595

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

Worksheet K-5 Part I Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

	Cost Center Description	SOCIAL SERVICE	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	
		17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	62,895				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	14,749	0	14,749	833	4.00
5.00	Nursing Care	0	524,358	0	524,358	29,599	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	87,311	0	87,311	4,929	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	56,800	0	56,800	3,206	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	10,242	0	10,242	578	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	23,402	0	23,402	1,321	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	397,340	0	397,340	22,429	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	1,177,097	0	1,177,097		34.00
35.00	Unit Cost Multiplier (see instructions)					0.056448	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140143 Hospice CCN: 141595

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

Worksheet K-5 Part I Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

	Cost Center Description	Total Hospice Costs (cols. 26 ± 27)		
		28.00		
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	15,582		4.00
5.00	Nursing Care	553,957		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	92,240		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	60,006		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	10,820		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	24,723		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	419,769		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,177,097		34.00
35.00	Unit Cost Multiplier (see instructions)			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140143
Hospice CCN: 141595

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

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 11:35 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
		1.00	1.01	2.00	2.01	4.00	
1.00	Administrative and General	974	974	898	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	316,039	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	47,178	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	26,813	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)	974	974	898	0	390,030	34.00
35.00	Total cost to be allocated	8,151	151	201	0	90,460	35.00
36.00	Unit Cost Multiplier (see instructions)	8.368583	0.155031	0.223831	0.000000	0.231931	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140143
Hospice CCN: 141595

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

Worksheet K-5
Part II
Date/Time Prepared:
2/26/2016 11:35 am

Hospice I

	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	0	8,503	974	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	12,135	0	0	0	4.00
5.00	Nursing Care	0	412,672	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	67,969	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	43,097	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	8,427	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	19,255	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	326,929	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)		898,987	974	0	0	34.00
35.00	Total cost to be allocated		193,616	18,054	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)		0.215371	18.535934	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140143
Hospice CCN: 141595

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

Worksheet K-5
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
1.00	Administrative and General	0	0	0	2,676,808	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	485	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	100	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	94	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	679	0	2,676,808	0	34.00
35.00	Total cost to be allocated	0	31,933	0	34,507	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	47.029455	0.000000	0.012891	0.000000	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS | Provider CCN: 140143 Hospice CCN: 141595 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-5 Part III Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.267572	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.255081	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.356737	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.450594	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.169490	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.076388	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.000000	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	SONOGRAPHY	76.00	0.129179	0	0	10.00
10.01	AUDIOLOGY	76.01	0.601811	0	0	10.01
10.02	CARDIAC REHAB	76.02	0.368447	0	0	10.02
10.03	ECP	76.03				10.03
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140143 Hospice CCN: 141595

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

Worksheet K-6

Date/Time Prepared: 2/26/2016 11:35 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				1,177,097	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				6,240	2.00
3.00	Average cost per diem (line 1 divided by line 2)				188.64	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	5,302				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	1,000,169				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		488			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		92,056			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			450		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			84,888		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140143	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/26/2016 11:35 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	550,279	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	3,613	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)	17.02	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)	553,892	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