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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 4/28/2017 12:16 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 4/28/2017 Time: 12:16 am
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 BLESSING HOSPITAL (14-0015) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 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	172,778	-233,173	27,471	0	1.00
2.00	Subprovider - IPF	0	139,760	336		0	2.00
3.00	Subprovider - IRF	0	-19,674	148		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	176,077	-19,715		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		29,942		0	10.00
200.00	Total	0	468,941	-222,462	27,471	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: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 4/28/2017 12:14 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1005 BROADWAY	PO Box:			1.00
2.00	City: QUINCY	State: IL	Zip Code: 62301	County: ADAMS	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	BLESSING HOSPITAL	140015	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	BLESSING PSYCHIATRIC UNIT	14S015	99914	4	10/01/1993	N	P	O	4.00
5.00	Subprovider - IRF	BLESSING REHAB UNIT	14T015	99914	5	10/01/1985	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	BLESSING SKILLED CARE UNIT	145643	99914		06/20/1989	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	BLESSING HOME CARE	147031	99914		12/01/1984	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HOSPICE OF ADAMS COUNTY	141501	99914		06/01/1984				14.00
15.00	Hospital-Based Health Clinic - RHC	GOLDEN CLINIC	143422	99914		09/08/1996	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		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.	6,121	343	749	0	561	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.	302	0	29	0	14		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:14 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2015	09/30/2016	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			60.00

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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	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: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:14 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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	711,470	1,528,620	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.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:14 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H132	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	143.00

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

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

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	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)	0.01	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 4/28/2017 12:14 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	12/08/2010	03/07/2011	170.00
		1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 4/28/2017 12:14 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	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)	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	03/31/2017	Y	03/31/2017 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 4/28/2017 12:14 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
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	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CZIEGLER@BLESSINGHOSPITAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 4/28/2017 12:14 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2017 12:14 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	203	74,298	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		203	74,298	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	25	9,150	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		228	83,448	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	41	15,006		0	16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,588		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,320		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		307				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2017 12:14 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)	22,860	4,889	37,611			1.00
2.00	HMO and other (see instructions)	3,102	904				2.00
3.00	HMO IPF Subprovider	40	540				3.00
4.00	HMO IRF Subprovider	237	14				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	22,860	4,889	37,611			7.00
8.00	INTENSIVE CARE UNIT	2,589	721	4,750			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,260	2,390			13.00
14.00	Total (see instructions)	25,449	6,870	44,751	16.42	1,675.20	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,756	5,560	11,203	0.20	82.83	16.00
17.00	SUBPROVIDER - IRF	3,484	331	4,806	0.39	26.98	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,976	13	5,221	0.00	29.19	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	34,827	0	49,499	0.00	48.74	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	24.57	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,370	0	8,069	0.00	8.21	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				17.01	1,895.72	27.00
28.00	Observation Bed Days		0	6,667			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			922			30.00
31.00	Employee discount days - IRF			224			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 4/28/2017 12:14 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	5,723	1,846	11,183	1.00
2.00	HMO and other (see instructions)			704	150		2.00
3.00	HMO IPF Subprovider				101		3.00
4.00	HMO IRF Subprovider				1		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	5,723	1,846	11,183	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	257	950	1,961	16.00
17.00	SUBPROVIDER - IRF	0.00	0	244	21	334	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					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: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 4/28/2017 12:14 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	105,270,844	0	105,270,844	3,933,798.61	26.76	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		551,964	0	551,964	1,620.00	340.72	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		6,355,146	0	6,355,146	24,381.22	260.66	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		441,973	0	441,973	17,086.87	25.87	6.00
7.00	Interns & residents (in an approved program)	21.00	1,082,338	0	1,082,338	39,030.88	27.73	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 and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,475,946	-40,765	1,435,181	58,920.17	24.36	9.00
10.00	Excluded area salaries (see instructions)		14,355,674	1,018,348	15,374,022	562,344.26	27.34	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,342,080	0	2,342,080	32,760.00	71.49	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		406,508	0	406,508	2,339.00	173.80	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		11,238,067	0	11,238,067	410,530.18	27.37	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
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)		31,934,169	0	31,934,169			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,407,307	0	6,407,307			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		119,810	0	119,810			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,315,230	0	1,315,230			23.00
24.00	Wage-related costs (RHC/FQHC)		172,421	0	172,421			24.00
25.00	Interns & residents (in an approved program)		407,337	0	407,337			25.00
25.50	Home office wage-related		5,335,819	0	5,335,819			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	2,427,532	0	2,427,532	154,477.29	15.71	26.00
27.00	Administrative & General	5.00	13,621,770	-16,534	13,605,236	457,838.69	29.72	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 4/28/2017 12:14 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	
28.00	Administrative & General under contract (see inst.)		786,714	0	786,714	3,630.05	216.72	28.00
29.00	Maintenance & Repairs	6.00	2,362,097	0	2,362,097	117,574.32	20.09	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	49,688	0	49,688	3,789.04	13.11	31.00
32.00	Housekeeping	9.00	2,275,793	0	2,275,793	167,255.48	13.61	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,289,638	-1,591,527	698,111	54,880.45	12.72	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,591,527	1,591,527	125,114.47	12.72	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	5,928,014	-16,532	5,911,482	204,535.33	28.90	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
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	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: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 4/28/2017 12:14 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)		98,178,101	0	98,178,101	3,856,929.69	25.45	1.00
2.00	Excluded area salaries (see instructions)		15,831,620	977,583	16,809,203	621,264.43	27.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)		82,346,481	-977,583	81,368,898	3,235,665.26	25.15	3.00
4.00	Subtotal other wages & related costs (see inst.)		13,986,655	0	13,986,655	445,629.18	31.39	4.00
5.00	Subtotal wage-related costs (see inst.)		37,389,798	0	37,389,798	0.00	45.95	5.00
6.00	Total (sum of lines 3 thru 5)		133,722,934	-977,583	132,745,351	3,681,294.44	36.06	6.00
7.00	Total overhead cost (see instructions)		29,741,246	-33,066	29,708,180	1,289,095.12	23.05	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 4/28/2017 12:14 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	3,045,247	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	8,736,634	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)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	18,841,653	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	114,021	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	310,968	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	876,000	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	7,189,060	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	10,770	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	1,231,921	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	40,356,274	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: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 4/28/2017 12:14 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	2,689,258	40,356,274	1.00
2.00	Hospital	2,342,080	35,856,248	2.00
3.00	Subprovider - IPF	82,553	1,484,033	3.00
4.00	Subprovider - IRF	143,510	537,558	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	121,115	547,060	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	1,209,903	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	549,051	13.00
14.00	Hospital-Based Health Clinic RHC	0	172,421	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-4 | Date/Time Prepared: 4/28/2017 12:14 am

Home Health Agency I | PPS

		1.00	
0.00	County	ADAMS	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	9,374	0	1,882	11,256	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,081.00	0.00	791.00	1,872.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.01	0.00	1.01	4.00
5.00	Other Administrative Personnel		9.23	0.00	9.23	5.00
6.00	Direct Nursing Service		18.23	0.00	18.23	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		9.77	0.00	9.77	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		3.36	0.00	3.36	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.28	0.00	0.28	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		1.45	0.00	1.45	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		5.41	0.00	5.41	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00
20.01			99926			20.01
20.02			50089			20.02

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	12,449	4,362	310	263	17,384	21.00
22.00	Skilled Nursing Visit Charges	2,006,458	703,772	50,068	42,510	2,802,808	22.00
23.00	Physical Therapy Visits	8,791	420	93	143	9,447	23.00
24.00	Physical Therapy Visit Charges	1,416,796	67,976	14,994	23,102	1,522,868	24.00
25.00	Occupational Therapy Visits	2,579	213	3	27	2,822	25.00
26.00	Occupational Therapy Visit Charges	415,638	34,474	486	4,350	454,948	26.00
27.00	Speech Pathology Visits	179	38	1	0	218	27.00
28.00	Speech Pathology Visit Charges	28,870	6,156	162	0	35,188	28.00
29.00	Medical Social Service Visits	53	9	1	3	66	29.00
30.00	Medical Social Service Visit Charges	8,562	1,458	162	486	10,668	30.00
31.00	Home Health Aide Visits	3,686	1,151	1	52	4,890	31.00
32.00	Home Health Aide Visit Charges	330,480	103,164	90	4,680	438,414	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	27,737	6,193	409	488	34,827	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	4,206,804	917,000	65,962	75,128	5,264,894	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,519		148	31	1,698	36.00
37.00	Total Number of Outlier Episodes		120		5	125	37.00
38.00	Total Non-Routine Medical Supply Charges	53,669	34,154	562	872	89,257	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-7 | Date/Time Prepared: 4/28/2017 12:14 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	18	0	18	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	155	0	155	7.00
8.00		RHL	187	0	187	8.00
9.00		RMX	67	0	67	9.00
10.00		RML	21	0	21	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	6	0	6	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	83	0	83	15.00
16.00		RVB	50	0	50	16.00
17.00		RVA	10	0	10	17.00
18.00		RHC	907	0	907	18.00
19.00		RHB	1,118	0	1,118	19.00
20.00		RHA	294	0	294	20.00
21.00		RMC	182	0	182	21.00
22.00		RMB	294	0	294	22.00
23.00		RMA	65	0	65	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	5	0	5	27.00
28.00		ES1	151	0	151	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	8	0	8	30.00
31.00		HD2	16	0	16	31.00
32.00		HD1	9	0	9	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	63	0	63	34.00
35.00		HB2	8	0	8	35.00
36.00		HB1	91	0	91	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	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	21	0	21	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	7	0	7	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	20	0	20	46.00
47.00		CD2	7	0	7	47.00
48.00		CD1	6	0	6	48.00
49.00		CC2	4	0	4	49.00
50.00		CC1	22	0	22	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	10	0	10	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	54	0	54	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: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-7 | Date/Time Prepared: 4/28/2017 12:14 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	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	1	0	1	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	15	0	15	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	1	0	1	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,976	0	3,976	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	1,475,946	30.40	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,855,763			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-8 | Date/Time Prepared: 4/28/2017 12:14 am

RHC I | Cost

					1.00		
	Clinic Address and Identification						
1.00	Street				102 PRAIRIE MILLS ROAD		1.00
			City		State	ZIP Code	
			1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		GOLDEN		IL	62339	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			09:00	17:00	09:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		ADAMS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	09:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0015
Component CCN: 14-3422

Period:
From 10/01/2015
To 09/30/2016

Worksheet S-8

Date/Time Prepared:
4/28/2017 12:14 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	17:00				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2015 To 09/30/2016

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 4/28/2017 12:14 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 FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	13,309	348	987	14,644	11.00
12.00	Hospice Inpatient Respite Care	10	0	0	10	12.00
13.00	Hospice General Inpatient Care	163	17	30	210	13.00
14.00	Total Hospice Days	13,482	365	1,017	14,864	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	10	0	0	10	15.00
16.00	Hospice General Inpatient Care	163	17	30	210	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 4/28/2017 12:14 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)	0.229690	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	25,739,986	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	7,070,502	5.00
6.00	Medicaid charges	180,064,004	6.00
7.00	Medicaid cost (line 1 times line 6)	41,358,901	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)	8,548,413	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	8,548,413	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	13,398,943	2,934,405	16,333,348	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	3,077,603	674,003	3,751,606	21.00
22.00	Partial payment by patients approved for charity care	99,040	15,520	114,560	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,978,563	658,483	3,637,046	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)	12,944,367	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	1,028,861	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	11,915,506	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,736,873	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,373,919	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	14,922,332	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	0	0	1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING		7,734	7,734	27,934	35,668	1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT		371,544	371,544	53,652	425,196	1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT		6,136,410	6,136,410	1,059,829	7,196,239	1.03
1.04	00104	CAP REL COSTS-14TH STREET		195,288	195,288	878,054	1,073,342	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I		0	0	52,128	52,128	1.05
1.06	00106	CAP REL COSTS-BBC		0	0	269,779	269,779	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP		7,306,771	7,306,771	275,599	7,582,370	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,427,532	41,353,127	43,780,659	0	43,780,659	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,621,770	84,773,759	98,395,529	-165,238	98,230,291	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,362,097	4,909,384	7,271,481	0	7,271,481	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,688	1,110,271	1,159,959	0	1,159,959	8.00
9.00	00900	HOUSEKEEPING	2,275,793	916,903	3,192,696	0	3,192,696	9.00
10.00	01000	DIETARY	2,289,638	3,500,180	5,789,818	-4,024,502	1,765,316	10.00
11.00	01100	CAFETERIA	0	0	0	4,024,502	4,024,502	11.00
13.00	01300	NURSING ADMINISTRATION	5,928,014	602,467	6,530,481	-16,532	6,513,949	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
20.00	02000	NURSING SCHOOL	3,269,824	1,688,446	4,958,270	1,027,994	5,986,264	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,082,338	0	1,082,338	0	1,082,338	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,871,833	1,871,833	0	1,871,833	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	263,457	6,015	269,472	0	269,472	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	61,836	4,402	66,238	0	66,238	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	211,313	22,487	233,800	0	233,800	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,032,065	2,928,487	17,960,552	-741,789	17,218,763	30.00
31.00	03100	INTENSIVE CARE UNIT	3,369,492	2,066,788	5,436,280	-283,007	5,153,273	31.00
40.00	04000	SUBPROVIDER - IPF	3,910,326	269,983	4,180,309	-17,881	4,162,428	40.00
41.00	04100	SUBPROVIDER - IRF	1,435,915	289,180	1,725,095	-31,242	1,693,853	41.00
43.00	04300	NURSERY	479,733	82,449	562,182	-88,527	473,655	43.00
44.00	04400	SKILLED NURSING FACILITY	1,475,946	234,009	1,709,955	-53,958	1,655,997	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,784,650	18,920,675	27,705,325	-13,658,778	14,046,547	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,275,547	305,132	1,580,679	-138,409	1,442,270	52.00
53.00	05300	ANESTHESIOLOGY	178,063	626,435	804,498	-254,292	550,206	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,275,552	1,554,372	4,829,924	-393,098	4,436,826	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,043,663	408,788	1,452,451	0	1,452,451	55.00
57.00	05700	CT SCAN	497,225	489,477	986,702	0	986,702	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	296,594	111,933	408,527	0	408,527	58.00
60.00	06000	LABORATORY	3,144,531	3,385,447	6,529,978	-62,525	6,467,453	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	125,097	1,106,509	1,231,606	0	1,231,606	62.00
65.00	06500	RESPIRATORY THERAPY	2,172,456	439,181	2,611,637	-162,529	2,449,108	65.00
66.00	06600	PHYSICAL THERAPY	1,362,272	28,789	1,391,061	-1,120	1,389,941	66.00
67.00	06700	OCCUPATIONAL THERAPY	593,517	7,199	600,716	-665	600,051	67.00
68.00	06800	SPEECH PATHOLOGY	268,422	5,964	274,386	-972	273,414	68.00
69.00	06900	ELECTROCARDIOLOGY	1,711,480	5,371,609	7,083,089	-4,665,695	2,417,394	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	324,927	91,787	416,714	0	416,714	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	721,776	784,470	1,506,246	6,768,801	8,275,047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,996,502	12,996,502	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,708,768	13,055,610	16,764,378	-166	16,764,212	73.00
74.00	07400	RENAL DIALYSIS	0	678,019	678,019	-274	677,745	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	441,973	486,250	928,223	-995	927,228	88.00
90.00	09000	CLINIC	360,801	123,696	484,497	0	484,497	90.00
90.01	09001	OUTPATIENT INFUSION	233,709	27,899	261,608	-2,656	258,952	90.01
91.00	09100	EMERGENCY	10,000,041	1,778,853	11,778,894	-172,836	11,606,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,174,111	1,524,996	4,699,107	181	4,699,288	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,534,571	2,534,571	-2,534,571	0	113.00
116.00	11600	HOSPICE	1,423,869	699,547	2,123,416	20,770	2,144,186	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	104,665,821	215,195,125	319,860,946	-16,532	319,844,414	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	140,988	51,443	192,431	0	192,431	192.00
192.01	19201	FASTCARE	268,849	89,176	358,025	0	358,025	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	0	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 4/28/2017 12:14 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	
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	16,532	16,532	193.05
193.06	19306	RENTED SPACE	0	0	0	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	195,186	725,910	921,096	0	921,096	193.07
200.00		TOTAL (SUM OF LINES 118-199)	105,270,844	216,061,654	321,332,498	0	321,332,498	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0		1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	35,668		1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT	0	425,196		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT	-1,422,533	5,773,706		1.03
1.04	00104	CAP REL COSTS-14TH STREET	-878,053	195,289		1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	-39,249	12,879		1.05
1.06	00106	CAP REL COSTS-BBC	0	269,779		1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,910,291	13,492,661		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-28,182,276	15,598,383		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-45,298,560	52,931,731		5.00
6.00	00600	MAINTENANCE & REPAIRS	-842,690	6,428,791		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,053	1,171,012		8.00
9.00	00900	HOUSEKEEPING	-294,036	2,898,660		9.00
10.00	01000	DIETARY	-1,197,792	567,524		10.00
11.00	01100	CAFETERIA	-1,475,440	2,549,062		11.00
13.00	01300	NURSING ADMINISTRATION	-257,183	6,256,766		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16.00
20.00	02000	NURSING SCHOOL	-3,313,295	2,672,969		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,082,338		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	1,871,833		22.00
23.00	02300	PARAMED ED PRGM	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	-62,400	207,072		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	-24,290	41,948		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	-5,000	228,800		23.03
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-14,133	17,204,630		30.00
31.00	03100	INTENSIVE CARE UNIT	-1,442,953	3,710,320		31.00
40.00	04000	SUBPROVIDER - IPF	-4,838	4,157,590		40.00
41.00	04100	SUBPROVIDER - IRF	-9,207	1,684,646		41.00
43.00	04300	NURSERY	0	473,655		43.00
44.00	04400	SKILLED NURSING FACILITY	-580	1,655,417		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,007,915	13,038,632		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,442,270		52.00
53.00	05300	ANESTHESIOLOGY	0	550,206		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,436,826		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,452,451		55.00
57.00	05700	CT SCAN	0	986,702		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	408,527		58.00
60.00	06000	LABORATORY	-63,632	6,403,821		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,231,606		62.00
65.00	06500	RESPIRATORY THERAPY	-24,752	2,424,356		65.00
66.00	06600	PHYSICAL THERAPY	0	1,389,941		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	600,051		67.00
68.00	06800	SPEECH PATHOLOGY	0	273,414		68.00
69.00	06900	ELECTROCARDIOLOGY	-28,454	2,388,940		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-40,744	375,970		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,275,047		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,996,502		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,549,158	14,215,054		73.00
74.00	07400	RENAL DIALYSIS	0	677,745		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-41,729	885,499		88.00
90.00	09000	CLINIC	0	484,497		90.00
90.01	09001	OUTPATIENT INFUSION	0	258,952		90.01
91.00	09100	EMERGENCY	-6,101,328	5,504,730		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-300	4,698,988		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	76,553	2,220,739		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-88,624,623	231,219,791		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192,431		192.00
192.01	19201	FASTCARE	0	358,025		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
193.02	19302	DENMAN SERVICES	0	0		193.02
193.03	19303	MEALS ON WHEELS	0	0		193.03
193.04	19304	UNUSED SPACE	0	0		193.04
193.05	19305	HEALTH EDUCATION	0	16,532		193.05

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
193.06	19306	RENTED SPACE	0	0		193.06
193.07	19307	AUGUSTA PHARMACY	0	921,096		193.07
200.00		TOTAL (SUM OF LINES 118-199)	-88,624,623	232,707,875		200.00

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 4/28/2017 12:14 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	1,591,527	2,432,975	1.00
	TOTALS		1,591,527	2,432,975	
	B - RECLASS C-SECTION COSTS				
1.00	OPERATING ROOM	50.00	12,374	0	1.00
	TOTALS		12,374	0	
	C - RECLASS BBC RENT EXPENSE				
1.00	CAP REL COSTS-BBC	1.06	0	269,779	1.00
	TOTALS		0	269,779	
	D - RECLASS CAPITAL RELATED INS COST				
1.00	CAP REL COSTS-BUTLER BUILDING	1.01	0	27,934	1.00
2.00	CAP REL COSTS-OLD BLDG & FIXT	1.02	0	53,652	2.00
3.00	CAP REL COSTS-NEW BLDG & FIXT	1.03	0	77,497	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,138	4.00
	TOTALS		0	168,221	
	E - RECLASS VOLUNTEER SERVICES				
1.00	HOSPICE	116.00	16,534	4,278	1.00
	TOTALS		16,534	4,278	
	F - RECLASS HEALTH EDUCATION				
1.00	HEALTH EDUCATION	193.05	16,532	0	1.00
	TOTALS		16,532	0	
	G - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-NEW BLDG & FIXT	1.03	0	982,332	1.00
2.00	CAP REL COSTS-14TH STREET	1.04	0	878,054	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	266,461	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	407,724	4.00
	TOTALS		0	2,534,571	
	H - RECLASS ER PHYS MALP INSURANCE				
1.00	EMERGENCY	91.00	0	62,022	1.00
	TOTALS		0	62,022	
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,768,801	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,996,502	2.00
3.00	HOME HEALTH AGENCY	101.00	0	181	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	TOTALS		0	19,765,484	
	J - RECLASS PRECEPTOR PAY				
1.00	NURSING SCHOOL	20.00	1,027,994	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		1,027,994	0	

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 4/28/2017 12:14 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - RECLASS RENT EXPENSE					
1.00	CAP REL COSTS-MOB PHASE I	1.05	0	52,128		1.00
	TOTALS		0	52,128		
500.00	Grand Total: Increases		2,664,961	25,289,458		500.00

RECLASSIFICATIONS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 4/28/2017 12:14 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	1,591,527	2,432,975	0		1.00
	TOTALS		1,591,527	2,432,975			
	B - RECLASS C-SECTION COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	12,374	0	0		1.00
	TOTALS		12,374	0			
	C - RECLASS BBC RENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	269,779	10		1.00
	TOTALS		0	269,779			
	D - RECLASS CAPITAL RELATED INS COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	168,221	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	12		4.00
	TOTALS		0	168,221			
	E - RECLASS VOLUNTEER SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	16,534	4,278	0		1.00
	TOTALS		16,534	4,278			
	F - RECLASS HEALTH EDUCATION						
1.00	NURSING ADMINISTRATION	13.00	16,532	0	0		1.00
	TOTALS		16,532	0			
	G - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,534,571	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	11		4.00
	TOTALS		0	2,534,571			
	H - RECLASS ER PHYS MALP INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,022	0		1.00
	TOTALS		0	62,022			
	I - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	306,181	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	135,091	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	831	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	5,580	0		4.00
5.00	NURSERY	43.00	0	45,911	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	13,193	0		6.00
7.00	OPERATING ROOM	50.00	0	13,517,265	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	106,366	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	254,292	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	393,098	0		10.00
11.00	LABORATORY	60.00	0	62,525	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	162,529	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,120	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	665	0		14.00
15.00	SPEECH PATHOLOGY	68.00	0	972	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	4,665,695	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	166	0		17.00
18.00	RENAL DIALYSIS	74.00	0	274	0		18.00
19.00	RURAL HEALTH CLINIC	88.00	0	995	0		19.00
20.00	OUTPATIENT INFUSION	90.01	0	2,656	0		20.00
21.00	EMERGENCY	91.00	0	90,037	0		21.00
22.00	HOSPICE	116.00	0	42	0		22.00
	TOTALS		0	19,765,484			
	J - RECLASS PRECEPTOR PAY						
1.00	ADULTS & PEDIATRICS	30.00	435,608	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	147,916	0	0		2.00
3.00	SUBPROVIDER - IPF	40.00	17,050	0	0		3.00
4.00	SUBPROVIDER - IRF	41.00	25,662	0	0		4.00
5.00	NURSERY	43.00	42,616	0	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	40,765	0	0		6.00
7.00	OPERATING ROOM	50.00	153,887	0	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	19,669	0	0		8.00
9.00	EMERGENCY	91.00	144,821	0	0		9.00
	TOTALS		1,027,994	0			
	K - RECLASS RENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,128	10		1.00
	TOTALS		0	52,128			
500.00	Grand Total: Decreases		2,664,961	25,289,458			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 4/28/2017 12:14 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: 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	13,183,024	245,232	0	245,232	0	1.00
2.00	Land Improvements	7,763,984	146,471	0	146,471	1,284,277	2.00
3.00	Buildings and Fixtures	140,879,997	2,967,252	0	2,967,252	9,017,396	3.00
4.00	Building Improvements	3,564,673	0	0	0	0	4.00
5.00	Fixed Equipment	73,383,608	647,458	0	647,458	6,139,760	5.00
6.00	Movable Equipment	182,404,371	11,730,711	0	11,730,711	49,232,728	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	421,179,657	15,737,124	0	15,737,124	65,674,161	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	421,179,657	15,737,124	0	15,737,124	65,674,161	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	13,428,256	0	1.00
2.00	Land Improvements	6,626,178	0	2.00
3.00	Buildings and Fixtures	134,829,853	0	3.00
4.00	Building Improvements	3,564,673	0	4.00
5.00	Fixed Equipment	67,891,306	0	5.00
6.00	Movable Equipment	144,902,354	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	371,242,620	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	371,242,620	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 4/28/2017 12:14 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	7,734	0	0	0	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXT	371,544	0	0	0	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXT	6,136,410	0	0	0	0	1.03
1.04	CAP REL COSTS-14TH STREET	195,288	0	0	0	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	7,306,771	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,017,747	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	7,734	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXT	0	371,544	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXT	0	6,136,410	1.03
1.04	CAP REL COSTS-14TH STREET	0	195,288	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	1.05
1.06	CAP REL COSTS-BBC	0	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,306,771	2.00
3.00	Total (sum of lines 1-2)	0	14,017,747	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 4/28/2017 12:14 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	307,247	0	307,247	0.000875	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXT	153,442,202	0	153,442,202	0.436923	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXT	40,324,889	0	40,324,889	0.114824	0	1.03
1.04	CAP REL COSTS-14TH STREET	12,211,493	0	12,211,493	0.034772	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0.000000	0	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0.000000	0	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	144,902,354	0	144,902,354	0.412606	0	2.00
3.00	Total (sum of lines 1-2)	351,188,185	0	351,188,185	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	0	0	7,734	0	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXT	0	0	0	371,544	0	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXT	0	0	0	6,209,666	0	1.03
1.04	CAP REL COSTS-14TH STREET	0	0	0	195,288	0	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	12,879	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0	269,779	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,556,099	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,340,331	282,658	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-BUTLER BUILDING	0	27,934	0	0	35,668	1.01
1.02	CAP REL COSTS-OLD BLDG & FIXT	0	53,652	0	0	425,196	1.02
1.03	CAP REL COSTS-NEW BLDG & FIXT	-513,457	77,497	0	0	5,773,706	1.03
1.04	CAP REL COSTS-14TH STREET	1	0	0	0	195,289	1.04
1.05	CAP REL COSTS-MOB PHASE I	0	0	0	0	12,879	1.05
1.06	CAP REL COSTS-BBC	0	0	0	0	269,779	1.06
2.00	CAP REL COSTS-MVBLE EQUIP	-72,576	9,138	0	0	13,492,661	2.00
3.00	Total (sum of lines 1-2)	-586,032	168,221	0	0	20,205,178	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 4/28/2017 12:14 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BUTLER BUILDING (chapter 2)		0	CAP REL COSTS-BUTLER BUILDING	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-OLD BLDG & FIXT (chapter 2)		0	CAP REL COSTS-OLD BLDG & FIXT	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-NEW BLDG & FIXT (chapter 2)		0	CAP REL COSTS-NEW BLDG & FIXT	1.03	0	1.03
1.04	Investment income - CAP REL COSTS-14TH STREET (chapter 2)		0	CAP REL COSTS-14TH STREET	1.04	0	1.04
1.05	Investment income - CAP REL COSTS-MOB PHASE I (chapter 2)		0	CAP REL COSTS-MOB PHASE I	1.05	0	1.05
1.06	Investment income - CAP REL COSTS-BBC (chapter 2)		0	CAP REL COSTS-BBC	1.06	0	1.06
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-748,774	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-192,682	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-59,807	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-21,276,620			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	12,937,013			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,475,440	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	A	-2,367,574	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-3,222,939	NURSING SCHOOL	20.00	0	19.00
20.00	Vending machines	B	-28,198	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	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 4/28/2017 12:14 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	
26.01	Depreciation - CAP REL COSTS-BUTLER BUILDING		0	CAP REL COSTS-BUTLER BUILDING	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-OLD BLDG & FIXT		0	CAP REL COSTS-OLD BLDG & FIXT	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-NEW BLDG & FIXT		0	CAP REL COSTS-NEW BLDG & FIXT	1.03	0	26.03
26.04	Depreciation - CAP REL COSTS-14TH STREET		0	CAP REL COSTS-14TH STREET	1.04	0	26.04
26.05	Depreciation - CAP REL COSTS-MOB PHASE I		0	CAP REL COSTS-MOB PHASE I	1.05	0	26.05
26.06	Depreciation - CAP REL COSTS-BBC		0	CAP REL COSTS-BBC	1.06	0	26.06
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	6,372,636	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	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	RENTAL INSURANCE EXPENSE	A	-11,241	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	DAMAGED GOODS	B	-7,140	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CHILD CARE CENTER	B	-1,826,269	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03	BOOKKEEPING FEES	B	-134,918	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	RADIOLOGY TUITION	B	-62,400	PARAMED ED PRGM-RADIOLOGY	23.01	0	33.04
33.05	PRINT SHOP	B	-71,838	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	HEALTH PROMOTIONS	B	-114,932	NURSING ADMINISTRATION	13.00	0	33.06
33.07	HOUSEKEEPING SERVICES	B	-294,036	HOUSEKEEPING	9.00	0	33.07
33.08	ADVERTISING	A	-322,705	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	RENTAL PROPERTY EXPENSE	A	-513,457	CAP REL COSTS-NEW BLDG & FIXT	1.03	11	33.09
33.10	RENTAL PROPERTY EXPENSE	A	-72,576	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.10
33.11	REAL ESTATE TAXES ON RENTAL	A	-112,437	MAINTENANCE & REPAIRS	6.00	0	33.11
33.12	RENTAL PROPERTY EXPENSE	A	-47,681	MAINTENANCE & REPAIRS	6.00	0	33.12
33.13	INTEREST INCOME	A	-982,332	CAP REL COSTS-NEW BLDG & FIXT	1.03	11	33.13
33.14	INTEREST INCOME	A	-878,053	CAP REL COSTS-14TH STREET	1.04	11	33.14
33.15	INTEREST INCOME	A	-266,461	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.15
33.16	INTEREST INCOME	A	-407,724	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	DIETARY OUTSIDE SERVICES-SALARIES	A	-42,620	DIETARY	10.00	0	33.17
33.18	DIETARY OUTSIDE SERVICES-BENEFITS	A	-16,375	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	PHYSICIAN RECRUITMENT	A	-400,320	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	NURSING SCHOOL ADVERTISING	A	-30,356	NURSING SCHOOL	20.00	0	33.20
33.21	LOBBYING EXPENSE	A	-44,932	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	TRANSFER TO PARENT	A	-7,205,412	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	HOSPICE PROFESSIONAL FEES	A	-11,651	HOSPICE	116.00	0	33.23
33.24	HOME CARE PROFESSIONAL FEES	A	-300	HOME HEALTH AGENCY	101.00	0	33.24
33.25	ER PHYSICIAN BENEFITS	A	-809,387	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	ALCOHOL RELATED EXPENSES	A	-3,000	ADMINISTRATIVE & GENERAL	5.00	0	33.26
33.27	BOOK TO MEDICARE DEPRECIATION	A	73,256	CAP REL COSTS-NEW BLDG & FIXT	1.03	9	33.27
33.28	GROUND FEES	B	-62,389	MAINTENANCE & REPAIRS	6.00	0	33.28
33.29	LABORATORY TUITION	B	-24,290	PARAMED ED PRGM-LABORATORY	23.02	0	33.29
33.30	CV SURGEON BENEFITS	A	-105,726	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
33.31	SLEF-FUNDED HEALTH INSURANCE	A	-18,172,676	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.31
33.32	LEASED EQUIPMENT	B	-15,048	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.32
33.33	STUDER GROUP EXPENSE	A	-323,269	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	TRAUMA ON-CALL	A	-1,586,018	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	NON-HOSPITAL DEPRECIATION	A	-48,453	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.35
33.36	MISCELLANEOUS INCOME	B	-60,746	ADMINISTRATIVE & GENERAL	5.00	0	33.36
33.37	MISCELLANEOUS INCOME	B	-1,225	OPERATING ROOM	50.00	0	33.37
33.38	MISCELLANEOUS INCOME	B	-18,852	RESPIRATORY THERAPY	65.00	0	33.38

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 4/28/2017 12:14 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	
33.39	MISCELLANEOUS INCOME	B	-18,499	ELECTROENCEPHALOGRAPHY	70.00	0	33.39
33.40	MISCELLANEOUS INCOME	B	-7,990	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	MISCELLANEOUS INCOME	B	-1,009,062	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	MISCELLANEOUS INCOME	B	-3,632	LABORATORY	60.00	0	33.42
33.43	MISCELLANEOUS INCOME	B	-59,830	DRUGS CHARGED TO PATIENTS	73.00	0	33.43
33.44	MISCELLANEOUS INCOME	B	-21,640	ELECTROCARDIOLOGY	69.00	0	33.44
33.45	CARE COORDINATION	B	-125,556	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	MISCELLANEOUS INCOME	B	-72,286	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	MISCELLANEOUS INCOME	B	-2,675	ADMINISTRATIVE & GENERAL	5.00	0	33.47
33.48	CATERING REVENUE	B	-228,028	DIETARY	10.00	0	33.48
33.49	FLOOR STOCK REVENUE	B	-276,887	DIETARY	10.00	0	33.49
33.50	CHILDCARE CENTER SERVICES	B	-220,555	DIETARY	10.00	0	33.50
33.51	OUTSIDE CATERING	B	-4,910	DIETARY	10.00	0	33.51
33.52	BH JAVA	B	-392,742	DIETARY	10.00	0	33.52
33.53	BPS EXPENSES	A	-24,740,269	ADMINISTRATIVE & GENERAL	5.00	0	33.53
33.54	ECHO OUTREACH SALARIES	A	-4,898	ELECTROCARDIOLOGY	69.00	0	33.54
33.55	ECHO OUTREACH BENEFITS	A	-1,882	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.55
33.56	PHARMACY COVERAGE SALARIES	A	-45,084	DRUGS CHARGED TO PATIENTS	73.00	0	33.56
33.57	PHARMACY COVERAGE BENEFITS	A	-17,321	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.57
33.58	PHARMACY COVERAGE EXPENSES	A	-23,641	DRUGS CHARGED TO PATIENTS	73.00	0	33.58
33.59	INFORMATION SYSTEMS-WAGES	A	-4,438,555	ADMINISTRATIVE & GENERAL	5.00	0	33.59
33.60	INFORMATION SYSTEMS-BENEFITS	A	-2,009,616	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.60
33.61	INTEREST FROM INSURANCE	B	-205,296	ADMINISTRATIVE & GENERAL	5.00	0	33.61
33.62	PAIN MGMT-NP SALARIES	A	-93,965	OPERATING ROOM	50.00	0	33.62
33.63	PAIN MGMT-NP BENEFITS	A	-36,101	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.63
33.64	PAIN MGMT-NP EXPENSES	A	-512	OPERATING ROOM	50.00	0	33.64
33.65	COLLEGE OF NURSING LOBBYING	A	-60,000	NURSING SCHOOL	20.00	0	33.65
33.66	LOBBYING EXPENSE	A	-2,468	SUBPROVIDER - IRF	41.00	0	33.66
33.67	BCS ALLOCATION	A	-9,346,020	ADMINISTRATIVE & GENERAL	5.00	0	33.67
33.68	MISCELLANEOUS INCOME	B	-53,029	DRUGS CHARGED TO PATIENTS	73.00	0	33.68
33.69	MISCELLANEOUS INCOME	B	-5,000	PARAMED ED PRGM-PHARMACY	23.03	0	33.69
33.70	MISCELLANEOUS INCOME	B	-60,384	MAINTENANCE & REPAIRS	6.00	0	33.70
33.71	MISCELLANEOUS INCOME	B	-26,120	MAINTENANCE & REPAIRS	6.00	0	33.71
33.72	HOSPICE RESPITE AND INPATIENT PMTS	A	6,516	HOSPICE	116.00	0	33.72
33.73	HOSPITAL SERVICES TO HOSPICE PATIENT	A	81,688	HOSPICE	116.00	0	33.73
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-88,624,623				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: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 4/28/2017 12:14 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	6.00	MAINTENANCE & REPAIRS	BIO-MED	539,474	1,073,153	1.00
2.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	1,105,368	1,094,315	2.00
3.00	88.00	RURAL HEALTH CLINIC	EAST ADAMS RENT	31,963	76,561	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	29,682,101	10,783,500	4.00
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	BCS BENEFITS	0	5,122,709	4.02
4.03	1.05	CAP REL COSTS-MOB PHASE I	CARE COORDINATION RENT	12,879	52,128	4.03
4.04	10.00	DIETARY	DIETICIAN COSTS	0	3,852	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	DIETICIAN BENEFITS	0	1,480	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	0	5,092	4.06
4.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	ACCOUNTS PAYABLE BENEFITS	0	1,956	4.07
4.08	13.00	NURSING ADMINISTRATION	INFORMATICS/CARE MGMT COSTS	0	142,251	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	INFORMATICS/CARE MGMT BENEFI	0	54,144	4.09
4.10	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDIES WAGES	0	17,268	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT	SLEEP STUDIES BENEFITS	0	6,634	4.11
4.12	70.00	ELECTROENCEPHALOGRAPHY	SLEEP STUDIES EXPENSES	0	2,598	4.12
4.13	88.00	RURAL HEALTH CLINIC	BEHAVIORAL HEALTH PROVIDERS	18,777	15,908	4.13
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			31,390,562	18,453,549	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:					
6.00	G		0.00	DENMAN SERVICES	0.00	6.00
7.00	G		0.00	DENMAN SERVICES	0.00	7.00
8.00	G		0.00	BLESSING FOUND	0.00	8.00
9.00	B		0.00	BLESS CORP SVCS	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	BROTHER/SISTER				100.00

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

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

(1) 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: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-1 Date/Time Prepared: 4/28/2017 12:14 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	-533,679	0		1.00
2.00	11,053	0		2.00
3.00	-44,598	0		3.00
4.00	18,898,601	0		4.00
4.02	-5,122,709	0		4.02
4.03	-39,249	10		4.03
4.04	-3,852	0		4.04
4.05	-1,480	0		4.05
4.06	-5,092	0		4.06
4.07	-1,956	0		4.07
4.08	-142,251	0		4.08
4.09	-54,144	0		4.09
4.10	-17,268	0		4.10
4.11	-6,634	0		4.11
4.12	-2,598	0		4.12
4.13	2,869	0		4.13
5.00	12,937,013			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 4/28/2017 12:14 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,974,139	1,840,517	133,622	211,500	914	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	2,779	0	2,779	260,300	19	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	1,604,494	1,604,494	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	16,385	16,385	0	0	0	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	224,066	71,756	152,310	211,500	880	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	152,310	0	152,310	246,400	880	6.00
7.00	30.00	ADULTS & PEDIATRICS	25,258	0	25,258	211,500	175	7.00
8.00	30.00	ADULTS & PEDIATRICS	20,600	0	20,600	211,500	137	8.00
9.00	31.00	INTENSIVE CARE UNIT	1,347,023	1,347,023	0	0	0	9.00
10.00	31.00	INTENSIVE CARE UNIT	95,930	95,930	0	0	0	10.00
11.00	40.00	SUBPROVIDER - IPF	11,550	0	11,550	181,300	77	11.00
12.00	41.00	SUBPROVIDER - IRF	36,125	0	36,125	211,500	289	12.00
13.00	44.00	SKILLED NURSING FACILITY	1,800	0	1,800	211,500	12	13.00
14.00	50.00	OPERATING ROOM	24,000	0	24,000	211,500	120	14.00
15.00	60.00	LABORATORY	60,000	60,000	0	0	0	15.00
16.00	65.00	RESPIRATORY THERAPY	9,525	0	9,525	211,500	63	16.00
17.00	65.00	RESPIRATORY THERAPY	8,475	0	8,475	211,500	56	17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	12,500	0	12,500	211,500	100	18.00
19.00	69.00	ELECTROCARDIOLOGY	2,828	0	2,828	211,500	22	19.00
20.00	69.00	ELECTROCARDIOLOGY	6,300	0	6,300	246,400	42	20.00
21.00	70.00	ELECTROENCEPHALOGRAPHY	250	0	250	211,500	2	21.00
22.00	91.00	EMERGENCY	31,200	0	31,200	211,500	240	22.00
23.00	91.00	EMERGENCY	454,324	386,324	68,000	211,500	340	23.00
24.00	91.00	EMERGENCY	5,596,878	5,596,878	0	0	0	24.00
25.00	91.00	EMERGENCY	218,224	0	218,224	211,500	1,380	25.00
26.00	50.00	OPERATING ROOM	7,538	7,538	0	0	0	26.00
27.00	50.00	OPERATING ROOM	92,371	0	92,371	246,400	349	27.00
28.00	5.00	ADMINISTRATIVE & GENERAL	9,038,511	9,038,511	0	0	0	28.00
29.00	50.00	OPERATING ROOM	83,581	83,581	0	0	0	29.00
30.00	50.00	OPERATING ROOM	758,268	758,268	0	0	0	30.00
200.00			21,917,232	20,907,205	1,010,027		6,097	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	92,938	4,647	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	2,378	119	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	89,481	4,474	0	0	0	5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	104,246	5,212	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	17,795	890	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	13,930	697	0	0	0	8.00
9.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	9.00
10.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	10.00
11.00	40.00	SUBPROVIDER - IPF	6,712	336	0	0	0	11.00
12.00	41.00	SUBPROVIDER - IRF	29,386	1,469	0	0	0	12.00
13.00	44.00	SKILLED NURSING FACILITY	1,220	61	0	0	0	13.00
14.00	50.00	OPERATING ROOM	12,202	610	0	0	0	14.00
15.00	60.00	LABORATORY	0	0	0	0	0	15.00
16.00	65.00	RESPIRATORY THERAPY	6,406	320	0	0	0	16.00
17.00	65.00	RESPIRATORY THERAPY	5,694	285	0	0	0	17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	10,168	508	0	0	0	18.00
19.00	69.00	ELECTROCARDIOLOGY	2,237	112	0	0	0	19.00
20.00	69.00	ELECTROCARDIOLOGY	4,975	249	0	0	0	20.00
21.00	70.00	ELECTROENCEPHALOGRAPHY	203	10	0	0	0	21.00
22.00	91.00	EMERGENCY	24,404	1,220	0	0	0	22.00
23.00	91.00	EMERGENCY	34,572	1,729	0	0	0	23.00
24.00	91.00	EMERGENCY	0	0	0	0	0	24.00
25.00	91.00	EMERGENCY	140,322	7,016	0	0	0	25.00
26.00	50.00	OPERATING ROOM	0	0	0	0	0	26.00
27.00	50.00	OPERATING ROOM	41,343	2,067	0	0	0	27.00
28.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	28.00
29.00	50.00	OPERATING ROOM	0	0	0	0	0	29.00
30.00	50.00	OPERATING ROOM	0	0	0	0	0	30.00
200.00			640,612	32,031	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	92,938	40,684	1,881,201		1.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 4/28/2017 12:14 am

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
2.00	5.00	ADMINISTRATIVE & GENERAL	0	2,378	401	401		2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,604,494		3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	16,385		4.00
5.00	5.00	ADMINISTRATIVE & GENERAL	0	89,481	62,829	134,585		5.00
6.00	5.00	ADMINISTRATIVE & GENERAL	0	104,246	48,064	48,064		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	17,795	7,463	7,463		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	13,930	6,670	6,670		8.00
9.00	31.00	INTENSIVE CARE UNIT	0	0	0	1,347,023		9.00
10.00	31.00	INTENSIVE CARE UNIT	0	0	0	95,930		10.00
11.00	40.00	SUBPROVIDER - IPF	0	6,712	4,838	4,838		11.00
12.00	41.00	SUBPROVIDER - IRF	0	29,386	6,739	6,739		12.00
13.00	44.00	SKILLED NURSING FACILITY	0	1,220	580	580		13.00
14.00	50.00	OPERATING ROOM	0	12,202	11,798	11,798		14.00
15.00	60.00	LABORATORY	0	0	0	60,000		15.00
16.00	65.00	RESPIRATORY THERAPY	0	6,406	3,119	3,119		16.00
17.00	65.00	RESPIRATORY THERAPY	0	5,694	2,781	2,781		17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	0	10,168	2,332	2,332		18.00
19.00	69.00	ELECTROCARDIOLOGY	0	2,237	591	591		19.00
20.00	69.00	ELECTROCARDIOLOGY	0	4,975	1,325	1,325		20.00
21.00	70.00	ELECTROENCEPHALOGRAPHY	0	203	47	47		21.00
22.00	91.00	EMERGENCY	0	24,404	6,796	6,796		22.00
23.00	91.00	EMERGENCY	0	34,572	33,428	419,752		23.00
24.00	91.00	EMERGENCY	0	0	0	5,596,878		24.00
25.00	91.00	EMERGENCY	0	140,322	77,902	77,902		25.00
26.00	50.00	OPERATING ROOM	0	0	0	7,538		26.00
27.00	50.00	OPERATING ROOM	0	41,343	51,028	51,028		27.00
28.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	9,038,511		28.00
29.00	50.00	OPERATING ROOM	0	0	0	83,581		29.00
30.00	50.00	OPERATING ROOM	0	0	0	758,268		30.00
200.00			0	640,612	369,415	21,276,620		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXT	NEW BLDG & FIXT	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	35,668	0	35,668			1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT	425,196	0	0	425,196		1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT	5,773,706	0	0	0	5,773,706	1.03
1.04	00104	CAP REL COSTS-14TH STREET	195,289	0	0	0	0	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	12,879	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BBC	269,779	0	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,492,661					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,598,383	0	0	19,597	52,770	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,931,731	0	187	95,717	1,081,501	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,428,791	0	7,512	62,276	649,025	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,171,012	0	0	6,013	21,299	8.00
9.00	00900	HOUSEKEEPING	2,898,660	0	0	14,017	7,182	9.00
10.00	01000	DIETARY	567,524	0	0	0	111,795	10.00
11.00	01100	CAFETERIA	2,549,062	0	0	0	81,412	11.00
13.00	01300	NURSING ADMINISTRATION	6,256,766	0	0	13,757	4,097	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,843	67,720	16.00
20.00	02000	NURSING SCHOOL	2,672,969	0	27,080	0	207,939	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,082,338	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,871,833	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	207,072	0	0	0	4,882	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	41,948	0	0	0	4,882	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	228,800	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,204,630	0	0	2,917	1,267,100	30.00
31.00	03100	INTENSIVE CARE UNIT	3,710,320	0	0	35,439	109,704	31.00
40.00	04000	SUBPROVIDER - IPF	4,157,590	0	0	0	344,913	40.00
41.00	04100	SUBPROVIDER - IRF	1,684,646	0	0	17,549	52,363	41.00
43.00	04300	NURSERY	473,655	0	0	0	33,751	43.00
44.00	04400	SKILLED NURSING FACILITY	1,655,417	0	0	0	113,820	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,038,632	0	0	39,262	245,315	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,442,270	0	0	22,974	19,691	52.00
53.00	05300	ANESTHESIOLOGY	550,206	0	0	2,123	6,415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,436,826	0	0	5,161	153,192	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,452,451	0	0	0	130,293	55.00
57.00	05700	CT SCAN	986,702	0	0	2,045	9,188	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	408,527	0	0	0	19,615	58.00
60.00	06000	LABORATORY	6,403,821	0	0	2,339	101,822	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,231,606	0	0	0	3,643	62.00
65.00	06500	RESPIRATORY THERAPY	2,424,356	0	0	7,250	0	65.00
66.00	06600	PHYSICAL THERAPY	1,389,941	0	0	0	32,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	600,051	0	0	0	15,537	67.00
68.00	06800	SPEECH PATHOLOGY	273,414	0	0	0	5,261	68.00
69.00	06900	ELECTROCARDIOLOGY	2,388,940	0	0	28,561	42,778	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	375,970	0	0	7,389	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,275,047	0	305	0	51,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,996,502	0	584	0	98,624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,215,054	0	0	1,088	36,174	73.00
74.00	07400	RENAL DIALYSIS	677,745	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	885,499	0	0	0	0	88.00
90.00	09000	CLINIC	484,497	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	258,952	0	0	0	33,070	90.01
91.00	09100	EMERGENCY	5,504,730	0	0	19,817	139,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,698,988	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,220,739	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	231,219,791	0	35,668	409,134	5,360,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,941	7,513	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192,431	0	0	0	0	192.00
192.01	19201	FASTCARE	358,025	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXT	NEW BLDG & FIXT	
			0	1.00	1.01	1.02	1.03	
193.02	19302	DENMAN SERVICES	0	0	0	0	9,462	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	4,127	174,425	193.04
193.05	19305	HEALTH EDUCATION	16,532	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	0	1,994	222,123	193.06
193.07	19307	AUGUSTA PHARMACY	921,096	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	232,707,875	0	35,668	425,196	5,773,706	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			14TH STREET	MOB PHASE I	BBC	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			1.04	1.05	1.06	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET	195,289					1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	12,879				1.05
1.06	00106	CAP REL COSTS-BBC	0	0	269,779			1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP				13,492,661		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	783	0	0	119,427	15,790,960	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,248	12,879	157,669	4,324,411	1,522,969	5.00
6.00	00600	MAINTENANCE & REPAIRS	47,866	0	3,285	298,887	409,484	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	284	0	0	4,085	8,614	8.00
9.00	00900	HOUSEKEEPING	1,987	0	0	88,330	394,522	9.00
10.00	01000	DIETARY	0	0	0	103,894	112,966	10.00
11.00	01100	CAFETERIA	0	0	0	0	275,901	11.00
13.00	01300	NURSING ADMINISTRATION	9,086	0	22,112	885,391	1,000,360	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,243	0	32,161	133,839	0	16.00
20.00	02000	NURSING SCHOOL	4,776	0	0	34,021	745,053	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	187,630	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	760	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,181	0	0	0	45,672	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	2,658	10,720	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	36,632	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,061,138	2,530,402	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	94,804	558,480	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	17,313	674,923	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	24,706	244,476	41.00
43.00	04300	NURSERY	0	0	0	20,202	75,777	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	277	248,797	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,197,008	1,350,600	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	44,813	215,569	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	164,167	30,868	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	853,359	567,837	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	978,627	180,925	55.00
57.00	05700	CT SCAN	0	0	0	79,630	86,197	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	311,707	51,416	58.00
60.00	06000	LABORATORY	254	0	0	225,859	545,123	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,282	21,686	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	376,608	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,770	236,158	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,191	102,890	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,604	46,533	68.00
69.00	06900	ELECTROCARDIOLOGY	187	0	0	643,480	295,846	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	37,377	53,335	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,721	0	0	40,700	42,855	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,304	0	0	78,131	82,269	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	247	0	0	316,702	635,122	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,576	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	76,619	88.00
90.00	09000	CLINIC	0	0	0	0	62,547	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	40,515	90.01
91.00	09100	EMERGENCY	4,973	0	0	135,187	700,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,719	0	0	7,222	550,251	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	109,559	247,683	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	106,859	12,879	215,227	13,469,094	15,683,209	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,219	24,441	192.00
192.01	19201	FASTCARE	0	0	0	22,064	46,607	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	717	0	0	284	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			14TH STREET	MOB PHASE I	BBC	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			1.04	1.05	1.06	2.00	4.00	
193.04	19304	UNUSED SPACE	85,750	0	3,243	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	2,866	193.05
193.06	19306	RENTED SPACE	1,963	0	51,309	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	33,837	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	195,289	12,879	269,779	13,492,661	15,790,960	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	6.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	60,152,312	60,152,312				5.00
6.00	00600	MAINTENANCE & REPAIRS	7,907,126	2,756,400	10,663,526			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,211,307	422,258	68,570	1,702,135		8.00
9.00	00900	HOUSEKEEPING	3,404,698	1,186,868	117,298	37,533	4,746,397	9.00
10.00	01000	DIETARY	896,179	312,405	183,876	2,406	103,949	10.00
11.00	01100	CAFETERIA	2,906,375	1,013,154	133,903	0	75,665	11.00
13.00	01300	NURSING ADMINISTRATION	8,191,569	2,855,556	305,516	0	172,700	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,806	83,247	224,775	0	127,059	16.00
20.00	02000	NURSING SCHOOL	3,691,838	1,286,964	654,794	0	370,106	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,269,968	442,707	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,872,593	652,780	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	258,807	90,219	32,371	0	18,276	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	60,208	20,988	8,030	0	4,545	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	265,432	92,529	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,066,187	7,692,170	2,097,510	817,821	1,185,500	30.00
31.00	03100	INTENSIVE CARE UNIT	4,508,747	1,571,736	343,614	64,281	194,215	31.00
40.00	04000	SUBPROVIDER - IPF	5,194,739	1,810,870	567,300	36,307	320,646	40.00
41.00	04100	SUBPROVIDER - IRF	2,023,740	705,470	166,928	81,197	94,327	41.00
43.00	04300	NURSERY	603,385	210,338	55,513	13,094	31,378	43.00
44.00	04400	SKILLED NURSING FACILITY	2,018,311	703,577	187,206	30,387	105,786	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,870,817	5,881,116	584,263	129,994	330,219	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,745,317	608,412	138,168	59,656	78,082	52.00
53.00	05300	ANESTHESIOLOGY	753,779	262,765	20,325	0	11,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,016,375	2,097,290	275,728	32,589	155,826	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,742,296	955,956	214,301	28,810	121,112	55.00
57.00	05700	CT SCAN	1,163,762	405,684	24,527	8,147	13,876	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	791,265	275,833	32,262	2,296	18,227	58.00
60.00	06000	LABORATORY	7,279,218	2,537,514	183,471	2,243	103,707	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,264,217	440,702	5,992	0	3,384	62.00
65.00	06500	RESPIRATORY THERAPY	2,808,214	978,935	33,382	0	18,856	65.00
66.00	06600	PHYSICAL THERAPY	1,666,277	580,859	53,303	120	30,121	66.00
67.00	06700	OCCUPATIONAL THERAPY	723,669	252,269	25,554	0	14,456	67.00
68.00	06800	SPEECH PATHOLOGY	328,812	114,623	8,653	0	4,883	68.00
69.00	06900	ELECTROCARDIOLOGY	3,399,792	1,185,157	205,711	96,256	116,278	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	474,071	165,260	34,021	0	19,243	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,411,998	2,932,397	122,371	27,258	69,186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,259,414	4,622,192	234,922	52,329	132,764	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,204,387	5,300,204	69,597	0	39,355	73.00
74.00	07400	RENAL DIALYSIS	685,321	238,901	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	962,118	335,391	0	0	0	88.00
90.00	09000	CLINIC	547,044	190,698	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	332,537	115,921	54,392	0	30,749	90.01
91.00	09100	EMERGENCY	6,504,718	2,267,525	423,389	146,264	239,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,260,180	1,833,683	76,647	0	43,320	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,577,981	898,676	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	230,515,906	59,388,199	7,968,183	1,668,988	4,398,627	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,454	6,084	58,128	15,912	32,877	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	218,091	76,026	0	17,235	0	192.00
192.01	19201	FASTCARE	426,696	148,745	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	10,463	3,647	30,348	0	17,164	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	267,545	93,265	2,080,078	0	0	193.04
193.05	19305	HEALTH EDUCATION	19,398	6,762	0	0	0	193.05
193.06	19306	RENTED SPACE	277,389	96,697	526,789	0	297,729	193.06

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	6.00	8.00	9.00	
193.07	19307	AUGUSTA PHARMACY	954,933	332,887	0	0	0	193.07
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)	232,707,875	60,152,312	10,663,526	1,702,135	4,746,397	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,498,815					10.00
11.00	01100	CAFETERIA	0	4,129,097				11.00
13.00	01300	NURSING ADMINISTRATION	0	313,295	11,838,636			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	673,887		16.00
20.00	02000	NURSING SCHOOL	0	234,324	0	0	6,238,026	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	61,227	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	12,830	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	3,254	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	9,810	0	0		23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	888,095	932,730	4,219,890	396,829	4,294,586	30.00
31.00	03100	INTENSIVE CARE UNIT	111,807	182,996	827,894	49,961	501,199	31.00
40.00	04000	SUBPROVIDER - IPF	260,073	268,455	1,214,570	116,209	375,833	40.00
41.00	04100	SUBPROVIDER - IRF	116,198	86,348	390,678	51,921	0	41.00
43.00	04300	NURSERY	0	21,360	96,655	1,250	78,354	43.00
44.00	04400	SKILLED NURSING FACILITY	122,642	92,416	418,127	54,804	223,109	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	460,450	2,083,162	0	219,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,311	309,061	0	228,687	52.00
53.00	05300	ANESTHESIOLOGY	0	13,856	62,705	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	200,594	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	47,322	0	0	0	55.00
57.00	05700	CT SCAN	0	25,220	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,833	0	0	0	58.00
60.00	06000	LABORATORY	0	234,793	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9,204	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	126,088	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	58,510	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,323	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,194	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	90,276	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	21,702	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,011	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	49,941	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	151,376	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	18,956	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	12,615	0	0	0	90.01
91.00	09100	EMERGENCY	0	237,500	1,074,498	2,913	279,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	719,452	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	365,960	0	37,450	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,498,815	4,128,120	11,782,652	673,887	6,238,026	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	55,984	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	0	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	977	0	0	0	193.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
193.06	19306	RENTED SPACE	0	0	0	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,498,815	4,129,097	11,838,636	673,887	6,238,026	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			21.00	22.00	23.00	23.01	23.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,712,675					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		2,586,600				22.00
23.00	02300	PARAMED ED PRGM			0			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				412,503		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					97,025	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,083,162	1,635,868	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	86,596	130,783	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	29,311	44,267	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	57,196	86,381	0	0	0	41.00
43.00	04300	NURSERY	41,071	62,028	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,476	139,663	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	19,065	28,794	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,245	15,473	0	412,503	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	5,880	8,880	0	0	97,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	67,531	101,989	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	42,585	64,315	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	177,557	268,159	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,712,675	2,586,600	0	412,503	97,025	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	0	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			21.00	22.00	23.00	23.01	23.02	
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	0	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,712,675	2,586,600	0	412,503	97,025	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.03	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	367,771					23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	47,310,348	-2,719,030	44,591,318		30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,573,829	-217,379	8,356,450		31.00
40.00	04000	SUBPROVIDER - IPF	0	10,238,580	-73,578	10,165,002		40.00
41.00	04100	SUBPROVIDER - IRF	0	3,860,384	-143,577	3,716,807		41.00
43.00	04300	NURSERY	0	1,214,426	-103,099	1,111,327		43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,956,365	0	3,956,365		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	26,791,285	-232,139	26,559,146		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,235,694	0	3,235,694		52.00
53.00	05300	ANESTHESIOLOGY	0	1,172,796	-47,859	1,124,937		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,216,623	-25,718	9,190,905		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,109,797	0	4,109,797		55.00
57.00	05700	CT SCAN	0	1,641,216	0	1,641,216		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,134,716	0	1,134,716		58.00
60.00	06000	LABORATORY	0	10,452,731	-14,760	10,437,971		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,723,499	0	1,723,499		62.00
65.00	06500	RESPIRATORY THERAPY	0	3,965,475	0	3,965,475		65.00
66.00	06600	PHYSICAL THERAPY	0	2,389,190	0	2,389,190		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,045,271	0	1,045,271		67.00
68.00	06800	SPEECH PATHOLOGY	0	469,165	0	469,165		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,262,990	-169,520	5,093,470		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	821,197	-106,900	714,297		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,589,221	0	11,589,221		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,351,562	0	18,351,562		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,771	21,132,690	0	21,132,690		73.00
74.00	07400	RENAL DIALYSIS	0	924,222	0	924,222		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,297,509	0	1,297,509		88.00
90.00	09000	CLINIC	0	756,698	0	756,698		90.00
90.01	09001	OUTPATIENT INFUSION	0	546,214	0	546,214		90.01
91.00	09100	EMERGENCY	0	11,621,530	-445,716	11,175,814		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	7,933,282	0	7,933,282		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,880,067	0	3,880,067		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	367,771	226,618,572	-4,299,275	222,319,297		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	130,455	0	130,455		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	311,352	0	311,352		192.00
192.01	19201	FASTCARE	0	631,425	0	631,425		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.02	19302	DENMAN SERVICES	0	61,622	0	61,622		193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0		193.03

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.03	24.00	25.00	26.00		
193.04	19304	UNUSED SPACE	0	2,440,888	0	2,440,888		193.04
193.05	19305	HEALTH EDUCATION	0	27,137	0	27,137		193.05
193.06	19306	RENTED SPACE	0	1,198,604	0	1,198,604		193.06
193.07	19307	AUGUSTA PHARMACY	0	1,287,820	0	1,287,820		193.07
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	367,771	232,707,875	-4,299,275	228,408,600		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXT	NEW BLDG & FIXT	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,125	0	0	19,597	52,770	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	222,745	0	187	95,717	1,081,501	5.00
6.00	00600	MAINTENANCE & REPAIRS	945	0	7,512	62,276	649,025	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	6,013	21,299	8.00
9.00	00900	HOUSEKEEPING	0	0	0	14,017	7,182	9.00
10.00	01000	DIETARY	7,957	0	0	0	111,795	10.00
11.00	01100	CAFETERIA	0	0	0	0	81,412	11.00
13.00	01300	NURSING ADMINISTRATION	19,893	0	0	13,757	4,097	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	3,843	67,720	16.00
20.00	02000	NURSING SCHOOL	3,906	0	27,080	0	207,939	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	715	0	0	0	4,882	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	0	4,882	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	62,710	0	0	2,917	1,267,100	30.00
31.00	03100	INTENSIVE CARE UNIT	13,773	0	0	35,439	109,704	31.00
40.00	04000	SUBPROVIDER - IPF	3,960	0	0	0	344,913	40.00
41.00	04100	SUBPROVIDER - IRF	1,462	0	0	17,549	52,363	41.00
43.00	04300	NURSERY	0	0	0	0	33,751	43.00
44.00	04400	SKILLED NURSING FACILITY	8,620	0	0	0	113,820	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,184,797	0	0	39,262	245,315	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	570	0	0	22,974	19,691	52.00
53.00	05300	ANESTHESIOLOGY	16,818	0	0	2,123	6,415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	422,745	0	0	5,161	153,192	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	154	0	0	0	130,293	55.00
57.00	05700	CT SCAN	0	0	0	2,045	9,188	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	19,615	58.00
60.00	06000	LABORATORY	148,714	0	0	2,339	101,822	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	3,643	62.00
65.00	06500	RESPIRATORY THERAPY	82,630	0	0	7,250	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	32,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	15,537	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	5,261	68.00
69.00	06900	ELECTROCARDIOLOGY	275	0	0	28,561	42,778	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,976	0	0	7,389	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	76,666	0	305	0	51,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	147,175	0	584	0	98,624	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,088	36,174	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,107	0	0	0	0	88.00
90.00	09000	CLINIC	66,737	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	33,070	90.01
91.00	09100	EMERGENCY	2,582	0	0	19,817	139,632	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,661	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	135,764	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,721,182	0	35,668	409,134	5,360,183	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,941	7,513	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,852	0	0	0	0	192.00
192.01	19201	FASTCARE	56,403	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	0	0	9,462	193.02

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXT	NEW BLDG & FIXT	
			0	1.00	1.01	1.02	1.03	
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	4,127	174,425	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	0	1,994	222,123	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,813,437	0	35,668	425,196	5,773,706	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAPITAL RELATED COSTS 14TH STREET 1.04	MOB PHASE I 1.05	BBC 1.06	MVBLE EQUIP 2.00	Subtotal 2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	783	0	0	119,427	196,702	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,248	12,879	157,669	4,324,411	5,920,357	5.00
6.00	00600	MAINTENANCE & REPAIRS	47,866	0	3,285	298,887	1,069,796	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	284	0	0	4,085	31,681	8.00
9.00	00900	HOUSEKEEPING	1,987	0	0	88,330	111,516	9.00
10.00	01000	DIETARY	0	0	0	103,894	223,646	10.00
11.00	01100	CAFETERIA	0	0	0	0	81,412	11.00
13.00	01300	NURSING ADMINISTRATION	9,086	0	22,112	885,391	954,336	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,243	0	32,161	133,839	238,806	16.00
20.00	02000	NURSING SCHOOL	4,776	0	0	34,021	277,722	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	760	760	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,181	0	0	0	6,778	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	2,658	7,540	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,061,138	2,393,865	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	94,804	253,720	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	17,313	366,186	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	24,706	96,080	41.00
43.00	04300	NURSERY	0	0	0	20,202	53,953	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	277	122,717	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,197,008	3,666,382	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	44,813	88,048	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	164,167	189,523	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	853,359	1,434,457	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	978,627	1,109,074	55.00
57.00	05700	CT SCAN	0	0	0	79,630	90,863	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	311,707	331,322	58.00
60.00	06000	LABORATORY	254	0	0	225,859	478,988	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	7,282	10,925	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	89,880	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,770	40,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,191	20,728	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,604	8,865	68.00
69.00	06900	ELECTROCARDIOLOGY	187	0	0	643,480	715,281	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	37,377	89,742	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,721	0	0	40,700	170,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,304	0	0	78,131	327,818	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	247	0	0	316,702	354,211	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	7,576	7,576	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	33,107	88.00
90.00	09000	CLINIC	0	0	0	0	66,737	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	33,070	90.01
91.00	09100	EMERGENCY	4,973	0	0	135,187	302,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,719	0	0	7,222	17,602	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	109,559	245,323	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	106,859	12,879	215,227	13,469,094	22,330,226	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	17,454	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,219	37,071	192.00
192.01	19201	FASTCARE	0	0	0	22,064	78,467	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	717	0	0	284	10,463	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	85,750	0	3,243	0	267,545	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			14TH STREET	MOB PHASE I	BBC	MVBLE EQUIP	Subtotal	
			1.04	1.05	1.06	2.00	2A	
193.06	19306	RENTED SPACE	1,963	0	51,309	0	277,389	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
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)	195,289	12,879	269,779	13,492,661	23,018,615	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	6.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	196,702					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,967	5,939,324				5.00
6.00	00600	MAINTENANCE & REPAIRS	5,100	272,163	1,347,059			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	107	41,693	8,662	82,143		8.00
9.00	00900	HOUSEKEEPING	4,913	117,190	14,818	1,811	250,248	9.00
10.00	01000	DIETARY	1,407	30,846	23,228	116	5,481	10.00
11.00	01100	CAFETERIA	3,436	100,037	16,915	0	3,989	11.00
13.00	01300	NURSING ADMINISTRATION	12,459	281,954	38,594	0	9,105	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,220	28,395	0	6,699	16.00
20.00	02000	NURSING SCHOOL	9,279	127,073	82,716	0	19,513	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,337	43,712	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	64,455	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	569	8,908	4,089	0	964	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	134	2,072	1,014	0	240	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	456	9,136	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	31,551	759,478	264,966	39,468	62,504	30.00
31.00	03100	INTENSIVE CARE UNIT	6,955	155,191	43,407	3,102	10,240	31.00
40.00	04000	SUBPROVIDER - IPF	8,406	178,803	71,664	1,752	16,906	40.00
41.00	04100	SUBPROVIDER - IRF	3,045	69,657	21,087	3,919	4,973	41.00
43.00	04300	NURSERY	944	20,769	7,013	632	1,654	43.00
44.00	04400	SKILLED NURSING FACILITY	3,099	69,470	23,649	1,466	5,577	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,821	580,694	73,806	6,273	17,410	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,685	60,074	17,454	2,879	4,117	52.00
53.00	05300	ANESTHESIOLOGY	384	25,945	2,568	0	607	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,072	207,084	34,831	1,573	8,216	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,253	94,390	27,071	1,390	6,386	55.00
57.00	05700	CT SCAN	1,074	40,057	3,098	393	732	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	640	27,235	4,075	111	961	58.00
60.00	06000	LABORATORY	6,789	250,551	23,177	108	5,468	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	270	43,514	757	0	178	62.00
65.00	06500	RESPIRATORY THERAPY	4,690	96,659	4,217	0	994	65.00
66.00	06600	PHYSICAL THERAPY	2,941	57,353	6,733	6	1,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,281	24,909	3,228	0	762	67.00
68.00	06800	SPEECH PATHOLOGY	580	11,318	1,093	0	257	68.00
69.00	06900	ELECTROCARDIOLOGY	3,685	117,021	25,986	4,645	6,131	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	664	16,318	4,298	0	1,015	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	534	289,541	15,458	1,315	3,648	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,025	456,389	29,676	2,525	7,000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,910	523,335	8,792	0	2,075	73.00
74.00	07400	RENAL DIALYSIS	0	23,589	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	954	33,116	0	0	0	88.00
90.00	09000	CLINIC	779	18,829	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	505	11,446	6,871	0	1,621	90.01
91.00	09100	EMERGENCY	8,723	223,892	53,484	7,059	12,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,853	181,055	9,682	0	2,284	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,085	88,734	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	195,361	5,863,875	1,006,572	80,543	231,913	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	601	7,343	768	1,733	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	304	7,507	0	832	0	192.00
192.01	19201	FASTCARE	580	14,687	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	360	3,834	0	905	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	9,209	262,764	0	0	193.04
193.05	19305	HEALTH EDUCATION	36	668	0	0	0	193.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	6.00	8.00	9.00	
193.06	19306	RENTED SPACE	0	9,548	66,546	0	15,697	193.06
193.07	19307	AUGUSTA PHARMACY	421	32,869	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	196,702	5,939,324	1,347,059	82,143	250,248	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	284,724					10.00
11.00	01100	CAFETERIA	0	205,789				11.00
13.00	01300	NURSING ADMINISTRATION	0	15,614	1,312,062			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	282,120		16.00
20.00	02000	NURSING SCHOOL	0	11,678	0	0	527,981	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	3,051	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0		23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	639	0	0		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	162	0	0		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	489	0	0		23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	168,707	46,488	467,685	166,132		30.00
31.00	03100	INTENSIVE CARE UNIT	21,240	9,120	91,755	20,916		31.00
40.00	04000	SUBPROVIDER - IPF	49,405	13,379	134,609	48,650		40.00
41.00	04100	SUBPROVIDER - IRF	22,074	4,303	43,298	21,737		41.00
43.00	04300	NURSERY	0	1,065	10,712	523		43.00
44.00	04400	SKILLED NURSING FACILITY	23,298	4,606	46,341	22,943		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	22,948	230,874	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,405	34,253	0		52.00
53.00	05300	ANESTHESIOLOGY	0	691	6,950	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,997	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,358	0	0		55.00
57.00	05700	CT SCAN	0	1,257	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	739	0	0		58.00
60.00	06000	LABORATORY	0	11,702	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	459	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	6,284	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,916	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,461	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	608	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,499	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,082	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,296	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,489	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,544	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	945	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	629	0	0		90.01
91.00	09100	EMERGENCY	0	11,837	119,085	1,219		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	79,736	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	40,559	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	284,724	205,740	1,305,857	282,120	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	FASTCARE	0	0	6,205	0		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.02	19302	DENMAN SERVICES	0	0	0	0		193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0		193.03
193.04	19304	UNUSED SPACE	0	0	0	0		193.04
193.05	19305	HEALTH EDUCATION	0	49	0	0		193.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	
			10.00	11.00	13.00	16.00	20.00	
193.06	19306	RENTED SPACE	0	0	0	0		193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0		193.07
200.00		Cross Foot Adjustments					527,981	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	284,724	205,789	1,312,062	282,120	527,981	202.00

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		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			21.00	22.00	23.00	23.01	23.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	46,049					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		68,266				22.00
23.00	02300	PARAMED ED PRGM			0			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY				21,947		23.01
23.02	02302	PARAMED ED PRGM-LABORATORY					11,162	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY						23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS						30.00
31.00	03100	INTENSIVE CARE UNIT						31.00
40.00	04000	SUBPROVIDER - IPF						40.00
41.00	04100	SUBPROVIDER - IRF						41.00
43.00	04300	NURSERY						43.00
44.00	04400	SKILLED NURSING FACILITY						44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM						50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM						52.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
55.00	05500	RADIOLOGY-THERAPEUTIC						55.00
57.00	05700	CT SCAN						57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)						58.00
60.00	06000	LABORATORY						60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS						62.00
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
67.00	06700	OCCUPATIONAL THERAPY						67.00
68.00	06800	SPEECH PATHOLOGY						68.00
69.00	06900	ELECTROCARDIOLOGY						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
74.00	07400	RENAL DIALYSIS						74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC						90.00
90.01	09001	OUTPATIENT INFUSION						90.01
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY						101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE						116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
192.01	19201	FASTCARE						192.01
193.00	19300	NONPAID WORKERS						193.00
193.02	19302	DENMAN SERVICES						193.02
193.03	19303	MEALS ON WHEELS						193.03

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		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	PARAMED ED PRGM-LABORATORY	
			21.00	22.00	23.00	23.01	23.02	
193.04	19304	UNUSED SPACE						193.04
193.05	19305	HEALTH EDUCATION						193.05
193.06	19306	RENTED SPACE						193.06
193.07	19307	AUGUSTA PHARMACY						193.07
200.00		Cross Foot Adjustments	46,049	68,266	0	21,947	11,162	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	46,049	68,266	0	21,947	11,162	202.00

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		Cost Center Description	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.03	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22.00
23.00	02300	PARAMED ED PRGM						23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY						23.01
23.02	02302	PARAMED ED PRGM-LABORATORY						23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	10,081					23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,400,844	0	4,400,844		30.00
31.00	03100	INTENSIVE CARE UNIT		615,646	0	615,646		31.00
40.00	04000	SUBPROVIDER - IPF		889,760	0	889,760		40.00
41.00	04100	SUBPROVIDER - IRF		290,173	0	290,173		41.00
43.00	04300	NURSERY		97,265	0	97,265		43.00
44.00	04400	SKILLED NURSING FACILITY		323,166	0	323,166		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		4,615,208	0	4,615,208		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		212,915	0	212,915		52.00
53.00	05300	ANESTHESIOLOGY		226,668	0	226,668		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,703,230	0	1,703,230		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		1,242,922	0	1,242,922		55.00
57.00	05700	CT SCAN		137,474	0	137,474		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		365,083	0	365,083		58.00
60.00	06000	LABORATORY		776,783	0	776,783		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS		56,103	0	56,103		62.00
65.00	06500	RESPIRATORY THERAPY		202,724	0	202,724		65.00
66.00	06600	PHYSICAL THERAPY		111,715	0	111,715		66.00
67.00	06700	OCCUPATIONAL THERAPY		52,369	0	52,369		67.00
68.00	06800	SPEECH PATHOLOGY		22,721	0	22,721		68.00
69.00	06900	ELECTROCARDIOLOGY		877,248	0	877,248		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		113,119	0	113,119		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		482,554	0	482,554		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		826,922	0	826,922		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		903,867	0	903,867		73.00
74.00	07400	RENAL DIALYSIS		31,165	0	31,165		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		67,177	0	67,177		88.00
90.00	09000	CLINIC		87,290	0	87,290		90.00
90.01	09001	OUTPATIENT INFUSION		54,142	0	54,142		90.01
91.00	09100	EMERGENCY		740,108	0	740,108		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY		297,212	0	297,212		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE		377,701	0	377,701		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	21,201,274	0	21,201,274		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		27,899	0	27,899		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		45,714	0	45,714		192.00
192.01	19201	FASTCARE		99,939	0	99,939		192.01
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.02	19302	DENMAN SERVICES		15,562	0	15,562		193.02
193.03	19303	MEALS ON WHEELS		0	0	0		193.03

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.03	24.00	25.00	26.00		
193.04	19304	UNUSED SPACE		539,518	0	539,518		193.04
193.05	19305	HEALTH EDUCATION		753	0	753		193.05
193.06	19306	RENTED SPACE		369,180	0	369,180		193.06
193.07	19307	AUGUSTA PHARMACY		33,290	0	33,290		193.07
200.00		Cross Foot Adjustments	10,081	685,486	0	685,486		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	10,081	23,018,615	0	23,018,615		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	0					1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING	0	18,142				1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT	0	0	125,798			1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT	0	0	0	610,192		1.03
1.04	00104	CAP REL COSTS-14TH STREET	0	0	0	0	258,595	1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	0	0	0	0	0	1.05
1.06	00106	CAP REL COSTS-BBC	0	0	0	0	0	1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,798	5,577	1,037	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	95	28,319	114,298	33,432	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	3,821	18,425	68,592	63,382	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,779	2,251	376	8.00
9.00	00900	HOUSEKEEPING	0	0	4,147	759	2,631	9.00
10.00	01000	DIETARY	0	0	0	11,815	0	10.00
11.00	01100	CAFETERIA	0	0	0	8,604	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4,070	433	12,032	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,137	7,157	1,646	16.00
20.00	02000	NURSING SCHOOL	0	13,774	0	21,976	6,324	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	516	1,564	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	0	516	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	863	133,913	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	10,485	11,594	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	36,452	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,192	5,534	0	41.00
43.00	04300	NURSERY	0	0	0	3,567	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	12,029	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	11,616	25,926	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,797	2,081	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	628	678	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,527	16,190	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,770	0	55.00
57.00	05700	CT SCAN	0	0	605	971	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	2,073	0	58.00
60.00	06000	LABORATORY	0	0	692	10,761	336	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	385	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,145	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,425	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,642	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	556	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,450	4,521	247	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2,186	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	155	0	5,429	2,279	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	297	0	10,423	4,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	322	3,823	327	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	3,495	0	90.01
91.00	09100	EMERGENCY	0	0	5,863	14,757	6,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	4,925	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,142	121,046	566,489	141,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2,941	794	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	0	0	0	1,000	950	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
193.04	19304	UNUSED SPACE	0	0	1,221	18,434	113,547	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	590	23,475	2,600	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	35,668	425,196	5,773,706	195,289	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1.966046	3.379990	9.462114	0.755192	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB PHASE I (SQUARE FEET)	BBC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.05	1.06	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I	2,472					1.05
1.06	00106	CAP REL COSTS-BBC	0	37,773				1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP			13,630,956			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	120,651	91,089,653		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,472	22,076	4,368,731	8,785,212	-60,152,312	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	460	301,951	2,362,097	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	4,127	49,688	0	8.00
9.00	00900	HOUSEKEEPING	0	0	89,235	2,275,793	0	9.00
10.00	01000	DIETARY	0	0	104,959	651,639	0	10.00
11.00	01100	CAFETERIA	0	0	0	1,591,527	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,096	894,466	5,770,555	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,503	135,211	0	0	16.00
20.00	02000	NURSING SCHOOL	0	0	34,370	4,297,818	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,082,338	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	768	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	0	0	0	263,457	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	0	0	2,685	61,836	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	0	0	0	211,313	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,072,015	14,596,457	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	95,776	3,221,576	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	17,490	3,893,276	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	24,959	1,410,253	0	41.00
43.00	04300	NURSERY	0	0	20,409	437,117	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	280	1,435,181	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	2,219,527	7,790,904	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	45,272	1,243,504	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	165,850	178,063	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	862,106	3,275,552	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	988,658	1,043,663	0	55.00
57.00	05700	CT SCAN	0	0	80,446	497,225	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	314,902	296,594	0	58.00
60.00	06000	LABORATORY	0	0	228,174	3,144,531	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	7,357	125,097	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,172,456	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	7,850	1,362,272	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,244	593,517	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,641	268,422	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	650,076	1,706,582	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	37,760	307,659	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	41,117	247,208	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	78,932	474,568	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	319,948	3,663,684	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	7,654	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	441,973	0	88.00
90.00	09000	CLINIC	0	0	0	360,801	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	233,709	0	90.01
91.00	09100	EMERGENCY	0	0	136,573	4,040,118	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	7,296	3,174,111	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	110,682	1,428,752	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,472	30,135	13,607,148	90,468,098	-60,152,312	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,231	140,988	0	192.00
192.01	19201	FASTCARE	0	0	22,290	268,849	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAPITAL RELATED COSTS					
			MOB PHASE I (SQUARE FEET)	BBC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.05	1.06	2.00	4.00	5A	
193.02	19302	DENMAN SERVICES	0	0	287	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	454	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	16,532	0	193.05
193.06	19306	RENTED SPACE	0	7,184	0	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	195,186	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,879	269,779	13,492,661	15,790,960		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.209951	7.142112	0.989854	0.173356		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				196,702		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.002159		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	172,555,563					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,907,126	685,188				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,211,307	4,406	1,131,998			8.00
9.00	00900	HOUSEKEEPING	3,404,698	7,537	24,961	98,171		9.00
10.00	01000	DIETARY	896,179	11,815	1,600	2,150	185,369	10.00
11.00	01100	CAFETERIA	2,906,375	8,604	0	1,565	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,191,569	19,631	0	3,572	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,806	14,443	0	2,628	0	16.00
20.00	02000	NURSING SCHOOL	3,691,838	42,074	0	7,655	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,269,968	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,872,593	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	258,807	2,080	0	378	0	23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	60,208	516	0	94	0	23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	265,432	0	0	0	0	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,066,187	134,776	543,888	24,520	109,837	30.00
31.00	03100	INTENSIVE CARE UNIT	4,508,747	22,079	42,750	4,017	13,828	31.00
40.00	04000	SUBPROVIDER - IPF	5,194,739	36,452	24,146	6,632	32,165	40.00
41.00	04100	SUBPROVIDER - IRF	2,023,740	10,726	54,000	1,951	14,371	41.00
43.00	04300	NURSERY	603,385	3,567	8,708	649	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,018,311	12,029	20,209	2,188	15,168	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,870,817	37,542	86,452	6,830	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,745,317	8,878	39,674	1,615	0	52.00
53.00	05300	ANESTHESIOLOGY	753,779	1,306	0	238	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,016,375	17,717	21,673	3,223	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,742,296	13,770	19,160	2,505	0	55.00
57.00	05700	CT SCAN	1,163,762	1,576	5,418	287	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	791,265	2,073	1,527	377	0	58.00
60.00	06000	LABORATORY	7,279,218	11,789	1,492	2,145	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,264,217	385	0	70	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,808,214	2,145	0	390	0	65.00
66.00	06600	PHYSICAL THERAPY	1,666,277	3,425	80	623	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	723,669	1,642	0	299	0	67.00
68.00	06800	SPEECH PATHOLOGY	328,812	556	0	101	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,399,792	13,218	64,015	2,405	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	474,071	2,186	0	398	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,411,998	7,863	18,128	1,431	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,259,414	15,095	34,801	2,746	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,204,387	4,472	0	814	0	73.00
74.00	07400	RENAL DIALYSIS	685,321	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	962,118	0	0	0	0	88.00
90.00	09000	CLINIC	547,044	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	332,537	3,495	0	636	0	90.01
91.00	09100	EMERGENCY	6,504,718	27,205	97,272	4,950	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,260,180	4,925	0	896	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,577,981	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	170,363,594	511,998	1,109,954	90,978	185,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,454	3,735	10,582	680	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	218,091	0	11,462	0	0	192.00
192.01	19201	FASTCARE	426,696	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	DENMAN SERVICES	10,463	1,950	0	355	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	267,545	133,656	0	0	0	193.04

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	6.00	8.00	9.00	10.00	
193.05	19305	HEALTH EDUCATION	19,398	0	0	0	0	193.05
193.06	19306	RENTED SPACE	277,389	33,849	0	6,158	0	193.06
193.07	19307	AUGUSTA PHARMACY	954,933	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	60,152,312	10,663,526	1,702,135	4,746,397	1,498,815	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.348597	15.562920	1.503655	48.348260	8.085575	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,939,324	1,347,059	82,143	250,248	284,724	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.034420	1.965970	0.072565	2.549103	1.535985	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
			11.00	13.00	16.00	20.00	21.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	422,577					11.00
13.00	01300	NURSING ADMINISTRATION	32,063	1,668,231				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	156,397			16.00
20.00	02000	NURSING SCHOOL	23,981	0	0	23,486		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0		19,224	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	6,266	0	0			22.00
23.00	02300	PARAMED ED PRGM	0	0	0			23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY	1,313	0	0			23.01
23.02	02302	PARAMED ED PRGM-LABORATORY	333	0	0			23.02
23.03	02303	PARAMED ED PRGM-PHARMACY	1,004	0	0			23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,457	594,642	92,097	16,169	12,158	30.00
31.00	03100	INTENSIVE CARE UNIT	18,728	116,662	11,595	1,887	972	31.00
40.00	04000	SUBPROVIDER - IPF	27,474	171,150	26,970	1,415	329	40.00
41.00	04100	SUBPROVIDER - IRF	8,837	55,052	12,050	0	642	41.00
43.00	04300	NURSERY	2,186	13,620	290	295	461	43.00
44.00	04400	SKILLED NURSING FACILITY	9,458	58,920	12,719	840	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,123	293,547	0	825	1,038	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,991	43,551	0	861	0	52.00
53.00	05300	ANESTHESIOLOGY	1,418	8,836	0	0	214	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,529	0	0	0	115	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,843	0	0	0	0	55.00
57.00	05700	CT SCAN	2,581	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,518	0	0	0	0	58.00
60.00	06000	LABORATORY	24,029	0	0	0	66	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	942	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	12,904	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,988	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,001	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,248	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,239	0	0	0	758	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,221	0	0	0	478	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,662	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,111	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,492	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,940	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	1,291	0	0	0	0	90.01
91.00	09100	EMERGENCY	24,306	151,412	676	1,053	1,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	101,381	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	51,569	0	141	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	422,477	1,660,342	156,397	23,486	19,224	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	7,889	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
			11.00	13.00	16.00	20.00	21.00	
193.02	19302	DENMAN SERVICES	0	0	0	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	100	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	0	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,129,097	11,838,636	673,887	6,238,026	1,712,675	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.771230	7.096521	4.308823	265.606148	89.090460	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	205,789	1,312,062	282,120	527,981	46,049	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.486986	0.786499	1.803871	22.480669	2.395391	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
			22.00	23.00	23.01	23.02	23.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BUTLER BUILDING						1.01
1.02	00102	CAP REL COSTS-OLD BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-NEW BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-14TH STREET						1.04
1.05	00105	CAP REL COSTS-MOB PHASE I						1.05
1.06	00106	CAP REL COSTS-BBC						1.06
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	19,224					22.00
23.00	02300	PARAMED ED PRGM		0				23.00
23.01	02301	PARAMED ED PRGM-RADIOLOGY			100			23.01
23.02	02302	PARAMED ED PRGM-LABORATORY				100		23.02
23.03	02303	PARAMED ED PRGM-PHARMACY					100	23.03
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,158	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	972	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	329	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	642	0	0	0	0	41.00
43.00	04300	NURSERY	461	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,038	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	214	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115	0	100	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	66	0	0	100	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	758	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	478	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,993	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,224	0	100	100	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FASTCARE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 4/28/2017 12:14 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)	
			22.00	23.00	23.01	23.02	23.03	
193.02	19302	DENMAN SERVICES	0	0	0	0	0	193.02
193.03	19303	MEALS ON WHEELS	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	HEALTH EDUCATION	0	0	0	0	0	193.05
193.06	19306	RENTED SPACE	0	0	0	0	0	193.06
193.07	19307	AUGUSTA PHARMACY	0	0	0	0	0	193.07
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,586,600	0	412,503	97,025	367,771	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	134.550562	0.000000	4,125.030000	970.250000	3,677.710000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,266	0	21,947	11,162	10,081	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.551082	0.000000	219.470000	111.620000	100.810000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | 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	44,591,318		44,591,318	14,133	44,605,451	30.00
31.00	03100	INTENSIVE CARE UNIT	8,356,450		8,356,450	0	8,356,450	31.00
40.00	04000	SUBPROVIDER - IPF	10,165,002		10,165,002	4,838	10,169,840	40.00
41.00	04100	SUBPROVIDER - IRF	3,716,807		3,716,807	6,739	3,723,546	41.00
43.00	04300	NURSERY	1,111,327		1,111,327	0	1,111,327	43.00
44.00	04400	SKILLED NURSING FACILITY	3,956,365		3,956,365	580	3,956,945	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,559,146		26,559,146	62,826	26,621,972	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,235,694		3,235,694	0	3,235,694	52.00
53.00	05300	ANESTHESIOLOGY	1,124,937		1,124,937	0	1,124,937	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,190,905		9,190,905	0	9,190,905	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,109,797		4,109,797	0	4,109,797	55.00
57.00	05700	CT SCAN	1,641,216		1,641,216	0	1,641,216	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,134,716		1,134,716	0	1,134,716	58.00
60.00	06000	LABORATORY	10,437,971		10,437,971	0	10,437,971	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,723,499		1,723,499	0	1,723,499	62.00
65.00	06500	RESPIRATORY THERAPY	3,965,475	0	3,965,475	5,900	3,971,375	65.00
66.00	06600	PHYSICAL THERAPY	2,389,190	0	2,389,190	0	2,389,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,045,271	0	1,045,271	0	1,045,271	67.00
68.00	06800	SPEECH PATHOLOGY	469,165	0	469,165	0	469,165	68.00
69.00	06900	ELECTROCARDIOLOGY	5,093,470		5,093,470	1,916	5,095,386	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	714,297		714,297	2,379	716,676	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,589,221		11,589,221	0	11,589,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,351,562		18,351,562	0	18,351,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,132,690		21,132,690	0	21,132,690	73.00
74.00	07400	RENAL DIALYSIS	924,222		924,222	0	924,222	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,297,509		1,297,509	0	1,297,509	88.00
90.00	09000	CLINIC	756,698		756,698	0	756,698	90.00
90.01	09001	OUTPATIENT INFUSION	546,214		546,214	0	546,214	90.01
91.00	09100	EMERGENCY	11,175,814		11,175,814	118,126	11,293,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,716,336		6,716,336		6,716,336	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,933,282		7,933,282		7,933,282	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,880,067		3,880,067		3,880,067	116.00
200.00		Subtotal (see instructions)	229,035,633	0	229,035,633	217,437	229,253,070	200.00
201.00		Less Observation Beds	6,716,336		6,716,336		6,716,336	201.00
202.00		Total (see instructions)	222,319,297	0	222,319,297	217,437	222,536,734	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | 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	71,271,779		71,271,779			30.00
31.00	03100	INTENSIVE CARE UNIT	33,924,364		33,924,364			31.00
40.00	04000	SUBPROVIDER - IPF	23,224,726		23,224,726			40.00
41.00	04100	SUBPROVIDER - IRF	5,671,327		5,671,327			41.00
43.00	04300	NURSERY	3,137,504		3,137,504			43.00
44.00	04400	SKILLED NURSING FACILITY	4,773,254		4,773,254			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,330,256	70,959,084	102,289,340	0.259647	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,809,666	783,144	6,592,810	0.490791	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,740,153	13,560,175	22,300,328	0.050445	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,853,575	29,520,731	42,374,306	0.216898	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	661,789	16,525,346	17,187,135	0.239121	0.000000	55.00
57.00	05700	CT SCAN	21,805,800	40,982,144	62,787,944	0.026139	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,070,267	13,178,577	19,248,844	0.058950	0.000000	58.00
60.00	06000	LABORATORY	45,786,652	58,367,502	104,154,154	0.100217	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,375,965	1,699,655	5,075,620	0.339564	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	15,368,942	3,491,325	18,860,267	0.210256	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,843,937	516,131	4,360,068	0.547971	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,706,238	93,686	2,799,924	0.373321	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	876,264	365,282	1,241,546	0.377888	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	35,225,406	47,244,433	82,469,839	0.061762	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	270,364	2,412,059	2,682,423	0.266288	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,572,830	34,995,677	68,568,507	0.169017	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,035,217	23,998,510	56,033,727	0.327509	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,201,323	39,064,431	121,265,754	0.174268	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,979,036	0	1,979,036	0.467006	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	847,527	847,527			88.00
90.00	09000	CLINIC	930	548,577	549,507	1.377049	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	36,446	1,768,467	1,804,913	0.302626	0.000000	90.01
91.00	09100	EMERGENCY	12,598,087	31,796,670	44,394,757	0.251737	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,920,331	22,125,441	25,045,772	0.268162	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	7,206,803	7,206,803			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	48,083	3,736,954	3,785,037			116.00
200.00		Subtotal (see instructions)	502,120,511	465,788,331	967,908,842			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	502,120,511	465,788,331	967,908,842			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
40.00	04000	SUBPROVIDER - IPF	
41.00	04100	SUBPROVIDER - IRF	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.260261
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791
53.00	05300	ANESTHESIOLOGY	0.050445
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121
57.00	05700	CT SCAN	0.026139
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950
60.00	06000	LABORATORY	0.100217
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564
65.00	06500	RESPIRATORY THERAPY	0.210568
66.00	06600	PHYSICAL THERAPY	0.547971
67.00	06700	OCCUPATIONAL THERAPY	0.373321
68.00	06800	SPEECH PATHOLOGY	0.377888
69.00	06900	ELECTROCARDIOLOGY	0.061785
70.00	07000	ELECTROENCEPHALOGRAPHY	0.267175
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268
74.00	07400	RENAL DIALYSIS	0.467006
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
90.00	09000	CLINIC	1.377049
90.01	09001	OUTPATIENT INFUSION	0.302626
91.00	09100	EMERGENCY	0.254398
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162
		OTHER REIMBURSABLE COST CENTERS	
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
116.00	11600	HOSPICE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:14 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	44,591,318		44,591,318	14,133	44,605,451	30.00
31.00	03100	INTENSIVE CARE UNIT	8,356,450		8,356,450	0	8,356,450	31.00
40.00	04000	SUBPROVIDER - IPF	10,165,002		10,165,002	4,838	10,169,840	40.00
41.00	04100	SUBPROVIDER - IRF	3,716,807		3,716,807	6,739	3,723,546	41.00
43.00	04300	NURSERY	1,111,327		1,111,327	0	1,111,327	43.00
44.00	04400	SKILLED NURSING FACILITY	3,956,365		3,956,365	580	3,956,945	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,559,146		26,559,146	62,826	26,621,972	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,235,694		3,235,694	0	3,235,694	52.00
53.00	05300	ANESTHESIOLOGY	1,124,937		1,124,937	0	1,124,937	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,190,905		9,190,905	0	9,190,905	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,109,797		4,109,797	0	4,109,797	55.00
57.00	05700	CT SCAN	1,641,216		1,641,216	0	1,641,216	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,134,716		1,134,716	0	1,134,716	58.00
60.00	06000	LABORATORY	10,437,971		10,437,971	0	10,437,971	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,723,499		1,723,499	0	1,723,499	62.00
65.00	06500	RESPIRATORY THERAPY	3,965,475	0	3,965,475	5,900	3,971,375	65.00
66.00	06600	PHYSICAL THERAPY	2,389,190	0	2,389,190	0	2,389,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,045,271	0	1,045,271	0	1,045,271	67.00
68.00	06800	SPEECH PATHOLOGY	469,165	0	469,165	0	469,165	68.00
69.00	06900	ELECTROCARDIOLOGY	5,093,470		5,093,470	1,916	5,095,386	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	714,297		714,297	2,379	716,676	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,589,221		11,589,221	0	11,589,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,351,562		18,351,562	0	18,351,562	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,132,690		21,132,690	0	21,132,690	73.00
74.00	07400	RENAL DIALYSIS	924,222		924,222	0	924,222	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,297,509		1,297,509	0	1,297,509	88.00
90.00	09000	CLINIC	756,698		756,698	0	756,698	90.00
90.01	09001	OUTPATIENT INFUSION	546,214		546,214	0	546,214	90.01
91.00	09100	EMERGENCY	11,175,814		11,175,814	118,126	11,293,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,716,336		6,716,336		6,716,336	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7,933,282		7,933,282		7,933,282	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	3,880,067		3,880,067		3,880,067	116.00
200.00		Subtotal (see instructions)	229,035,633	0	229,035,633	217,437	229,253,070	200.00
201.00		Less Observation Beds	6,716,336		6,716,336		6,716,336	201.00
202.00		Total (see instructions)	222,319,297	0	222,319,297	217,437	222,536,734	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I | Date/Time Prepared: 4/28/2017 12:14 am

Title XIX | Hospital | Cost

		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	71,271,779		71,271,779			30.00
31.00	03100	INTENSIVE CARE UNIT	33,924,364		33,924,364			31.00
40.00	04000	SUBPROVIDER - IPF	23,224,726		23,224,726			40.00
41.00	04100	SUBPROVIDER - IRF	5,671,327		5,671,327			41.00
43.00	04300	NURSERY	3,137,504		3,137,504			43.00
44.00	04400	SKILLED NURSING FACILITY	4,773,254		4,773,254			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,330,256	70,959,084	102,289,340	0.259647	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,809,666	783,144	6,592,810	0.490791	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,740,153	13,560,175	22,300,328	0.050445	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,853,575	29,520,731	42,374,306	0.216898	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	661,789	16,525,346	17,187,135	0.239121	0.000000	55.00
57.00	05700	CT SCAN	21,805,800	40,982,144	62,787,944	0.026139	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,070,267	13,178,577	19,248,844	0.058950	0.000000	58.00
60.00	06000	LABORATORY	45,786,652	58,367,502	104,154,154	0.100217	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,375,965	1,699,655	5,075,620	0.339564	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	15,368,942	3,491,325	18,860,267	0.210256	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,843,937	516,131	4,360,068	0.547971	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,706,238	93,686	2,799,924	0.373321	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	876,264	365,282	1,241,546	0.377888	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	35,225,406	47,244,433	82,469,839	0.061762	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	270,364	2,412,059	2,682,423	0.266288	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,572,830	34,995,677	68,568,507	0.169017	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,035,217	23,998,510	56,033,727	0.327509	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,201,323	39,064,431	121,265,754	0.174268	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,979,036	0	1,979,036	0.467006	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	847,527	847,527	1.530935	0.000000	88.00
90.00	09000	CLINIC	930	548,577	549,507	1.377049	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION	36,446	1,768,467	1,804,913	0.302626	0.000000	90.01
91.00	09100	EMERGENCY	12,598,087	31,796,670	44,394,757	0.251737	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,920,331	22,125,441	25,045,772	0.268162	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	7,206,803	7,206,803			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	48,083	3,736,954	3,785,037			116.00
200.00		Subtotal (see instructions)	502,120,511	465,788,331	967,908,842			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	502,120,511	465,788,331	967,908,842			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 4/28/2017 12:14 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT INFUSION	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 4/28/2017 12:14 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	4,400,844	0	4,400,844	44,278	99.39	30.00
31.00	INTENSIVE CARE UNIT	615,646		615,646	4,750	129.61	31.00
40.00	SUBPROVIDER - IPF	889,760	0	889,760	11,203	79.42	40.00
41.00	SUBPROVIDER - IRF	290,173	0	290,173	4,806	60.38	41.00
43.00	NURSERY	97,265		97,265	2,390	40.70	43.00
44.00	SKILLED NURSING FACILITY	323,166		323,166	5,221	61.90	44.00
200.00	Total (lines 30-199)	6,616,854		6,616,854	72,648		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	22,860	2,272,055	30.00
31.00	INTENSIVE CARE UNIT	2,589	335,560	31.00
40.00	SUBPROVIDER - IPF	1,756	139,462	40.00
41.00	SUBPROVIDER - IRF	3,484	210,364	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,976	246,114	44.00
200.00	Total (lines 30-199)	34,665	3,203,555	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 4/28/2017 12:14 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	4,615,208	102,289,340	0.045119	15,818,008	713,693	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	212,915	6,592,810	0.032295	20,745	670	52.00
53.00	05300	ANESTHESIOLOGY	226,668	22,300,328	0.010164	4,278,561	43,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,703,230	42,374,306	0.040195	7,611,321	305,937	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,242,922	17,187,135	0.072317	397,461	28,743	55.00
57.00	05700	CT SCAN	137,474	62,787,944	0.002189	11,357,180	24,861	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	365,083	19,248,844	0.018966	3,250,833	61,655	58.00
60.00	06000	LABORATORY	776,783	104,154,154	0.007458	25,001,573	186,462	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	56,103	5,075,620	0.011053	1,917,756	21,197	62.00
65.00	06500	RESPIRATORY THERAPY	202,724	18,860,267	0.010749	9,633,220	103,547	65.00
66.00	06600	PHYSICAL THERAPY	111,715	4,360,068	0.025622	1,182,985	30,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,369	2,799,924	0.018704	647,096	12,103	67.00
68.00	06800	SPEECH PATHOLOGY	22,721	1,241,546	0.018301	345,607	6,325	68.00
69.00	06900	ELECTROCARDIOLOGY	877,248	82,469,839	0.010637	20,870,705	222,002	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113,119	2,682,423	0.042170	164,424	6,934	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	482,554	68,568,507	0.007038	18,241,649	128,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	826,922	56,033,727	0.014758	17,249,343	254,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	903,867	121,265,754	0.007454	42,284,628	315,190	73.00
74.00	07400	RENAL DIALYSIS	31,165	1,979,036	0.015748	889,609	14,010	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,177	847,527	0.079262	0	0	88.00
90.00	09000	CLINIC	87,290	549,507	0.158851	254	40	90.00
90.01	09001	OUTPATIENT INFUSION	54,142	1,804,913	0.029997	29,217	876	90.01
91.00	09100	EMERGENCY	740,108	44,394,757	0.016671	6,144,814	102,440	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	662,647	25,045,772	0.026457	1,764,457	46,682	92.00
200.00		Total (lines 50-199)	14,572,154	814,914,048		189,101,446	2,630,115	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,294,586	0	0	0	4,294,586	30.00
31.00	03100	INTENSIVE CARE UNIT	501,199	0	0		501,199	31.00
40.00	04000	SUBPROVIDER - IPF	375,833	0	0	0	375,833	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	78,354	0	0		78,354	43.00
44.00	04400	SKILLED NURSING FACILITY	223,109	0			223,109	44.00
200.00		Total (lines 30-199)	5,473,081	0	0		5,473,081	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	44,278	96.99	22,860	2,217,191		30.00
31.00	03100	INTENSIVE CARE UNIT	4,750	105.52	2,589	273,191		31.00
40.00	04000	SUBPROVIDER - IPF	11,203	33.55	1,756	58,914		40.00
41.00	04100	SUBPROVIDER - IRF	4,806	0.00	3,484	0		41.00
43.00	04300	NURSERY	2,390	32.78	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,221	42.73	3,976	169,894		44.00
200.00		Total (lines 30-199)	72,648		34,665	2,719,190		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | 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	219,125	0	0	219,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228,687	0	0	228,687	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	412,503	0	412,503	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	97,025	0	97,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	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	367,771	0	367,771	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	279,683	0	0	279,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	646,642	0	0	646,642	92.00
200.00		Total (lines 50-199)	0	1,374,137	877,299	0	2,251,436	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | 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	219,125	102,289,340	0.002142	0.002142	15,818,008	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,687	6,592,810	0.034687	0.034687	20,745	52.00
53.00	05300	ANESTHESIOLOGY	0	22,300,328	0.000000	0.000000	4,278,561	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	412,503	42,374,306	0.009735	0.009735	7,611,321	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,187,135	0.000000	0.000000	397,461	55.00
57.00	05700	CT SCAN	0	62,787,944	0.000000	0.000000	11,357,180	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,248,844	0.000000	0.000000	3,250,833	58.00
60.00	06000	LABORATORY	97,025	104,154,154	0.000932	0.000932	25,001,573	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,075,620	0.000000	0.000000	1,917,756	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,860,267	0.000000	0.000000	9,633,220	65.00
66.00	06600	PHYSICAL THERAPY	0	4,360,068	0.000000	0.000000	1,182,985	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,799,924	0.000000	0.000000	647,096	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,241,546	0.000000	0.000000	345,607	68.00
69.00	06900	ELECTROCARDIOLOGY	0	82,469,839	0.000000	0.000000	20,870,705	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,682,423	0.000000	0.000000	164,424	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	68,568,507	0.000000	0.000000	18,241,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,033,727	0.000000	0.000000	17,249,343	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,771	121,265,754	0.003033	0.003033	42,284,628	73.00
74.00	07400	RENAL DIALYSIS	0	1,979,036	0.000000	0.000000	889,609	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	847,527	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	549,507	0.000000	0.000000	254	90.00
90.01	09001	OUTPATIENT INFUSION	0	1,804,913	0.000000	0.000000	29,217	90.01
91.00	09100	EMERGENCY	279,683	44,394,757	0.006300	0.006300	6,144,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	646,642	25,045,772	0.025818	0.025818	1,764,457	92.00
200.00		Total (lines 50-199)	2,251,436	814,914,048			189,101,446	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | 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	33,882	23,442,412	50,214		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	720	4,633	161		52.00
53.00	05300	ANESTHESIOLOGY	0	4,497,736	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,096	8,342,930	81,218		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,263,474	0		55.00
57.00	05700	CT SCAN	0	11,244,240	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,835,200	0		58.00
60.00	06000	LABORATORY	23,301	8,296,683	7,733		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	707,586	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,638,683	0		65.00
66.00	06600	PHYSICAL THERAPY	0	67,331	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	36,403	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,598	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	22,736,079	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	712,057	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,578,630	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,304,179	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,249	12,755,121	38,686		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	5,913	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	975,316	0		90.01
91.00	09100	EMERGENCY	38,712	6,791,573	42,787		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	45,555	8,197,881	211,653		92.00
200.00		Total (lines 50-199)	344,515	147,440,658	432,452		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Hospital | PPS

		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	0.259647	23,442,412	1,153	0	6,086,752	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791	4,633	0	0	2,274	52.00
53.00	05300	ANESTHESIOLOGY	0.050445	4,497,736	0	0	226,888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898	8,342,930	0	0	1,809,565	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121	9,263,474	0	0	2,215,091	55.00
57.00	05700	CT SCAN	0.026139	11,244,240	0	0	293,913	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950	3,835,200	0	0	226,085	58.00
60.00	06000	LABORATORY	0.100217	8,296,683	270	0	831,469	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564	707,586	0	0	240,271	62.00
65.00	06500	RESPIRATORY THERAPY	0.210256	1,638,683	0	0	344,543	65.00
66.00	06600	PHYSICAL THERAPY	0.547971	67,331	0	0	36,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373321	36,403	0	0	13,590	67.00
68.00	06800	SPEECH PATHOLOGY	0.377888	6,598	0	0	2,493	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061762	22,736,079	0	0	1,404,226	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266288	712,057	0	0	189,612	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017	12,578,630	0	0	2,126,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509	11,304,179	0	0	3,702,220	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268	12,755,121	0	0	2,222,809	73.00
74.00	07400	RENAL DIALYSIS	0.467006	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.377049	5,913	0	0	8,142	90.00
90.01	09001	OUTPATIENT INFUSION	0.302626	975,316	0	0	295,156	90.01
91.00	09100	EMERGENCY	0.251737	6,791,573	0	0	1,709,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162	8,197,881	0	0	2,198,360	92.00
200.00		Subtotal (see instructions)		147,440,658	1,423	0	26,186,046	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		147,440,658	1,423	0	26,186,046	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Hospital | PPS

		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	299	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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	27	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	326	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	326	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,615,208	102,289,340	0.045119	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	212,915	6,592,810	0.032295	0	0	52.00
53.00	05300	ANESTHESIOLOGY	226,668	22,300,328	0.010164	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,703,230	42,374,306	0.040195	24,596	989	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,242,922	17,187,135	0.072317	0	0	55.00
57.00	05700	CT SCAN	137,474	62,787,944	0.002189	73,279	160	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	365,083	19,248,844	0.018966	11,094	210	58.00
60.00	06000	LABORATORY	776,783	104,154,154	0.007458	385,379	2,874	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	56,103	5,075,620	0.011053	1,625	18	62.00
65.00	06500	RESPIRATORY THERAPY	202,724	18,860,267	0.010749	18,807	202	65.00
66.00	06600	PHYSICAL THERAPY	111,715	4,360,068	0.025622	2,130	55	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,369	2,799,924	0.018704	359	7	67.00
68.00	06800	SPEECH PATHOLOGY	22,721	1,241,546	0.018301	584	11	68.00
69.00	06900	ELECTROCARDIOLOGY	877,248	82,469,839	0.010637	45,967	489	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113,119	2,682,423	0.042170	860	36	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	482,554	68,568,507	0.007038	2,784	20	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	826,922	56,033,727	0.014758	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	903,867	121,265,754	0.007454	513,590	3,828	73.00
74.00	07400	RENAL DIALYSIS	31,165	1,979,036	0.015748	10,015	158	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,177	847,527	0.079262	0	0	88.00
90.00	09000	CLINIC	87,290	549,507	0.158851	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	54,142	1,804,913	0.029997	0	0	90.01
91.00	09100	EMERGENCY	740,108	44,394,757	0.016671	199,046	3,318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	25,045,772	0.000000	0	0	92.00
200.00		Total (lines 50-199)	13,909,507	814,914,048		1,290,115	12,375	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	219,125	0	0	219,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228,687	0	0	228,687	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	412,503	0	412,503	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	97,025	0	97,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	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	367,771	0	367,771	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	279,683	0	0	279,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	727,495	877,299	0	1,604,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219,125	102,289,340	0.002142	0.002142	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,687	6,592,810	0.034687	0.034687	0	52.00
53.00	05300	ANESTHESIOLOGY	0	22,300,328	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	412,503	42,374,306	0.009735	0.009735	24,596	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,187,135	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	62,787,944	0.000000	0.000000	73,279	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,248,844	0.000000	0.000000	11,094	58.00
60.00	06000	LABORATORY	97,025	104,154,154	0.000932	0.000932	385,379	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,075,620	0.000000	0.000000	1,625	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,860,267	0.000000	0.000000	18,807	65.00
66.00	06600	PHYSICAL THERAPY	0	4,360,068	0.000000	0.000000	2,130	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,799,924	0.000000	0.000000	359	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,241,546	0.000000	0.000000	584	68.00
69.00	06900	ELECTROCARDIOLOGY	0	82,469,839	0.000000	0.000000	45,967	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,682,423	0.000000	0.000000	860	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	68,568,507	0.000000	0.000000	2,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,033,727	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,771	121,265,754	0.003033	0.003033	513,590	73.00
74.00	07400	RENAL DIALYSIS	0	1,979,036	0.000000	0.000000	10,015	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	847,527	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	549,507	0.000000	0.000000	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	1,804,913	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	279,683	44,394,757	0.006300	0.006300	199,046	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	25,045,772	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	1,604,794	814,914,048			1,290,115	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	359	4,095	4		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,186	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,558	929	3		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0		90.01
91.00	09100	EMERGENCY	1,254	4,229	27		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	3,410	10,439	34		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

		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	0.259647	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050445	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121	0	0	0	0	55.00
57.00	05700	CT SCAN	0.026139	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950	0	0	0	0	58.00
60.00	06000	LABORATORY	0.100217	4,095	0	0	410	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.210256	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.547971	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373321	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.377888	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061762	1,186	0	0	73	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266288	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268	929	0	5,203	162	73.00
74.00	07400	RENAL DIALYSIS	0.467006	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.377049	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.302626	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.251737	4,229	0	0	1,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162	0	0	0	0	92.00
200.00		Subtotal (see instructions)		10,439	0	5,203	1,710	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		10,439	0	5,203	1,710	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	907		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	907		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	907		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,615,208	102,289,340	0.045119	117,014	5,280	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	212,915	6,592,810	0.032295	0	0	52.00
53.00	05300	ANESTHESIOLOGY	226,668	22,300,328	0.010164	23,131	235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,703,230	42,374,306	0.040195	131,655	5,292	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,242,922	17,187,135	0.072317	0	0	55.00
57.00	05700	CT SCAN	137,474	62,787,944	0.002189	87,821	192	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	365,083	19,248,844	0.018966	26,085	495	58.00
60.00	06000	LABORATORY	776,783	104,154,154	0.007458	589,810	4,399	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	56,103	5,075,620	0.011053	32,798	363	62.00
65.00	06500	RESPIRATORY THERAPY	202,724	18,860,267	0.010749	146,222	1,572	65.00
66.00	06600	PHYSICAL THERAPY	111,715	4,360,068	0.025622	1,008,937	25,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,369	2,799,924	0.018704	796,811	14,904	67.00
68.00	06800	SPEECH PATHOLOGY	22,721	1,241,546	0.018301	266,015	4,868	68.00
69.00	06900	ELECTROCARDIOLOGY	877,248	82,469,839	0.010637	53,427	568	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113,119	2,682,423	0.042170	2,581	109	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	482,554	68,568,507	0.007038	94,619	666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	826,922	56,033,727	0.014758	124,463	1,837	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	903,867	121,265,754	0.007454	1,009,000	7,521	73.00
74.00	07400	RENAL DIALYSIS	31,165	1,979,036	0.015748	58,088	915	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,177	847,527	0.079262	0	0	88.00
90.00	09000	CLINIC	87,290	549,507	0.158851	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	54,142	1,804,913	0.029997	0	0	90.01
91.00	09100	EMERGENCY	740,108	44,394,757	0.016671	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	25,045,772	0.000000	0	0	92.00
200.00		Total (lines 50-199)	13,909,507	814,914,048		4,568,477	75,067	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	219,125	0	0	219,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228,687	0	0	228,687	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	412,503	0	412,503	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	97,025	0	97,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	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	367,771	0	367,771	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	279,683	0	0	279,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	727,495	877,299	0	1,604,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219,125	102,289,340	0.002142	0.002142	117,014	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,687	6,592,810	0.034687	0.034687	0	52.00
53.00	05300	ANESTHESIOLOGY	0	22,300,328	0.000000	0.000000	23,131	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	412,503	42,374,306	0.009735	0.009735	131,655	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,187,135	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	62,787,944	0.000000	0.000000	87,821	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,248,844	0.000000	0.000000	26,085	58.00
60.00	06000	LABORATORY	97,025	104,154,154	0.000932	0.000932	589,810	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,075,620	0.000000	0.000000	32,798	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,860,267	0.000000	0.000000	146,222	65.00
66.00	06600	PHYSICAL THERAPY	0	4,360,068	0.000000	0.000000	1,008,937	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,799,924	0.000000	0.000000	796,811	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,241,546	0.000000	0.000000	266,015	68.00
69.00	06900	ELECTROCARDIOLOGY	0	82,469,839	0.000000	0.000000	53,427	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,682,423	0.000000	0.000000	2,581	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	68,568,507	0.000000	0.000000	94,619	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,033,727	0.000000	0.000000	124,463	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,771	121,265,754	0.003033	0.003033	1,009,000	73.00
74.00	07400	RENAL DIALYSIS	0	1,979,036	0.000000	0.000000	58,088	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	847,527	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	549,507	0.000000	0.000000	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	1,804,913	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	279,683	44,394,757	0.006300	0.006300	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	25,045,772	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	1,604,794	814,914,048			4,568,477	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	251	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	1,282	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	550	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	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	3,060	426	1		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	5,143	426	1		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

		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	0.259647	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050445	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121	0	0	0	0	55.00
57.00	05700	CT SCAN	0.026139	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950	0	0	0	0	58.00
60.00	06000	LABORATORY	0.100217	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.210256	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.547971	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373321	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.377888	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061762	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266288	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268	426	0	2,734	74	73.00
74.00	07400	RENAL DIALYSIS	0.467006	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.377049	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.302626	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.251737	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162	0	0	0	0	92.00
200.00		Subtotal (see instructions)		426	0	2,734	74	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		426	0	2,734	74	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	476		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	476		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	476		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	219,125	0	0	219,125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	228,687	0	0	228,687	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	412,503	0	412,503	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	97,025	0	97,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	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	367,771	0	367,771	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	279,683	0	0	279,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	727,495	877,299	0	1,604,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	219,125	102,289,340	0.002142	0.002142	7,875	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	228,687	6,592,810	0.034687	0.034687	0	52.00
53.00	05300	ANESTHESIOLOGY	0	22,300,328	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	412,503	42,374,306	0.009735	0.009735	151,006	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	17,187,135	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	62,787,944	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,248,844	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	97,025	104,154,154	0.000932	0.000932	818,629	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,075,620	0.000000	0.000000	40,943	62.00
65.00	06500	RESPIRATORY THERAPY	0	18,860,267	0.000000	0.000000	552,139	65.00
66.00	06600	PHYSICAL THERAPY	0	4,360,068	0.000000	0.000000	602,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,799,924	0.000000	0.000000	490,377	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,241,546	0.000000	0.000000	34,066	68.00
69.00	06900	ELECTROCARDIOLOGY	0	82,469,839	0.000000	0.000000	29,492	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,682,423	0.000000	0.000000	6,023	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	68,568,507	0.000000	0.000000	139,065	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	56,033,727	0.000000	0.000000	710	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,771	121,265,754	0.003033	0.003033	2,481,330	73.00
74.00	07400	RENAL DIALYSIS	0	1,979,036	0.000000	0.000000	19,029	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	847,527	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	549,507	0.000000	0.000000	0	90.00
90.01	09001	OUTPATIENT INFUSION	0	1,804,913	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	279,683	44,394,757	0.006300	0.006300	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	25,045,772	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	1,604,794	814,914,048			5,373,658	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	17	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	1,470	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	763	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	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	7,526	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	9,776	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Skilled Nursing Facility | PPS

		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	0.259647	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050445	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121	0	0	0	0	55.00
57.00	05700	CT SCAN	0.026139	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950	0	0	0	0	58.00
60.00	06000	LABORATORY	0.100217	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.210256	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.547971	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373321	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.377888	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061762	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266288	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268	0	0	24,363	0	73.00
74.00	07400	RENAL DIALYSIS	0.467006	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.377049	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.302626	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.251737	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	24,363	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	24,363	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Skilled Nursing Facility | PPS

		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,246		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	4,246		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,246		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:14 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)	44,278	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	44,278	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)	37,611	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	22,860	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	44,605,451	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	44,605,451	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)	44,605,451	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)	1,007.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	23,029,164	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)	23,029,164	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:14 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	8,356,450	4,750	1,759.25	2,589	4,554,698	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)	32,678,678	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	60,262,540	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)	5,097,997	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,974,630	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	8,072,627	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	52,189,913	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)	6,667	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,007.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,716,336	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	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	4,400,844	44,605,451	0.098662	6,716,336	662,647	90.00
91.00	Nursing School cost	4,294,586	44,605,451	0.096279	6,716,336	646,642	91.00
92.00	Allied health cost	0	44,605,451	0.000000	6,716,336	0	92.00
93.00	All other Medical Education	0	44,605,451	0.000000	6,716,336	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,203	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,203	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)	11,203	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,756	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,169,840	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,169,840	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,169,840	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)	907.78	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,594,062	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,594,062	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	200,917	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,794,979	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)	198,376	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	15,785	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	214,161	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,580,818	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	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	889,760	10,169,840	0.087490	0	0	90.00
91.00	Nursing School cost	375,833	10,169,840	0.036956	0	0	91.00
92.00	Allied health cost	0	10,169,840	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,169,840	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,806	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,806	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,806	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,484	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,723,546	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,723,546	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,723,546	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)	774.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,699,299	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)	2,699,299	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,379,614	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,078,913	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)	210,364	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	80,210	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	290,574	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,788,339	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	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	290,173	3,723,546	0.077929	0	0	90.00
91.00	Nursing School cost	0	3,723,546	0.000000	0	0	91.00
92.00	Allied health cost	0	3,723,546	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,723,546	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,221	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,221	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)	5,221	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,976	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,956,945	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,956,945	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,956,945	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,956,945	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	757.89	71.00
72.00	Program routine service cost (line 9 x line 71)	3,013,371	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	3,013,371	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	3,013,371	83.00
84.00	Program inpatient ancillary services (see instructions)	1,241,651	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	4,255,022	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1

Component CCN: 14-5643 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/28/2017 12:14 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		46,034,719		30.00
31.00	03100	INTENSIVE CARE UNIT		18,474,404		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.260261	15,818,008	4,116,811	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791	20,745	10,181	52.00
53.00	05300	ANESTHESIOLOGY	0.050445	4,278,561	215,832	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898	7,611,321	1,650,880	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121	397,461	95,041	55.00
57.00	05700	CT SCAN	0.026139	11,357,180	296,865	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950	3,250,833	191,637	58.00
60.00	06000	LABORATORY	0.100217	25,001,573	2,505,583	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564	1,917,756	651,201	62.00
65.00	06500	RESPIRATORY THERAPY	0.210568	9,633,220	2,028,448	65.00
66.00	06600	PHYSICAL THERAPY	0.547971	1,182,985	648,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373321	647,096	241,575	67.00
68.00	06800	SPEECH PATHOLOGY	0.377888	345,607	130,601	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061785	20,870,705	1,289,497	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.267175	164,424	43,930	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017	18,241,649	3,083,149	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509	17,249,343	5,649,315	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268	42,284,628	7,368,858	73.00
74.00	07400	RENAL DIALYSIS	0.467006	889,609	415,453	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.377049	254	350	90.00
90.01	09001	OUTPATIENT INFUSION	0.302626	29,217	8,842	90.01
91.00	09100	EMERGENCY	0.254398	6,144,814	1,563,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162	1,764,457	473,160	92.00
200.00		Total (sum of lines 50-94 and 96-98)		189,101,446	32,678,678	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)		189,101,446		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		3,654,546		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.260261	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050445	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898	24,596	5,335	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121	0	0	55.00
57.00	05700	CT SCAN	0.026139	73,279	1,915	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950	11,094	654	58.00
60.00	06000	LABORATORY	0.100217	385,379	38,622	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564	1,625	552	62.00
65.00	06500	RESPIRATORY THERAPY	0.210568	18,807	3,960	65.00
66.00	06600	PHYSICAL THERAPY	0.547971	2,130	1,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373321	359	134	67.00
68.00	06800	SPEECH PATHOLOGY	0.377888	584	221	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061785	45,967	2,840	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.267175	860	230	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017	2,784	471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268	513,590	89,502	73.00
74.00	07400	RENAL DIALYSIS	0.467006	10,015	4,677	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.377049	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.302626	0	0	90.01
91.00	09100	EMERGENCY	0.254398	199,046	50,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,290,115	200,917	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,290,115		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		4,116,816		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.260261	117,014	30,454	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050445	23,131	1,167	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898	131,655	28,556	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121	0	0	55.00
57.00	05700	CT SCAN	0.026139	87,821	2,296	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950	26,085	1,538	58.00
60.00	06000	LABORATORY	0.100217	589,810	59,109	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564	32,798	11,137	62.00
65.00	06500	RESPIRATORY THERAPY	0.210568	146,222	30,790	65.00
66.00	06600	PHYSICAL THERAPY	0.547971	1,008,937	552,868	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373321	796,811	297,466	67.00
68.00	06800	SPEECH PATHOLOGY	0.377888	266,015	100,524	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061785	53,427	3,301	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.267175	2,581	690	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017	94,619	15,992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509	124,463	40,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268	1,009,000	175,836	73.00
74.00	07400	RENAL DIALYSIS	0.467006	58,088	27,127	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.377049	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.302626	0	0	90.01
91.00	09100	EMERGENCY	0.254398	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,568,477	1,379,614	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,568,477		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0015 | Component CCN: 14-5643 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.259647	7,875	2,045	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.490791	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050445	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216898	151,006	32,753	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.239121	0	0	55.00
57.00	05700	CT SCAN	0.026139	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.058950	0	0	58.00
60.00	06000	LABORATORY	0.100217	818,629	82,041	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.339564	40,943	13,903	62.00
65.00	06500	RESPIRATORY THERAPY	0.210256	552,139	116,091	65.00
66.00	06600	PHYSICAL THERAPY	0.547971	602,974	330,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.373321	490,377	183,068	67.00
68.00	06800	SPEECH PATHOLOGY	0.377888	34,066	12,873	68.00
69.00	06900	ELECTROCARDIOLOGY	0.061762	29,492	1,821	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.266288	6,023	1,604	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.169017	139,065	23,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.327509	710	233	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.174268	2,481,330	432,416	73.00
74.00	07400	RENAL DIALYSIS	0.467006	19,029	8,887	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.377049	0	0	90.00
90.01	09001	OUTPATIENT INFUSION	0.302626	0	0	90.01
91.00	09100	EMERGENCY	0.251737	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.268162	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,373,658	1,241,651	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)		5,373,658		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Hospital	PPS

		1.00	
	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)	44,140,566	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,660,010	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	5,222,206	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	209.78	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	19.50	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	19.50	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	17.01	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	17.01	12.00
13.00	Total allowable FTE count for the prior year.	17.42	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	16.06	14.00
15.00	Sum of lines 12 through 14 divided by 3.	16.83	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	16.83	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.080227	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.093152	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.080227	21.00
22.00	IME payment adjustment (see instructions)	1,891,865	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	223,824	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-2.49	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)	1,891,865	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	223,824	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5.23	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.02	31.00
32.00	Sum of lines 30 and 31	22.25	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.57	33.00
34.00	Disproportionate share adjustment (see instructions)	835,360	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 4/28/2017 12:14 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000189684	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	1,334,890	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	1,334,890	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,334,890		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
		Before 1/1	On/After 1/1	
		1.00	1.01	
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)	49,862,691		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	54,996,028		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		55,219,852	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,834,812	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).		630,023	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
54.01	Islet isolation add-on payment			54.01
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).		2,490,382	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		344,515	58.00
59.00	Total (sum of amounts on lines 49 through 58)		62,519,584	59.00
60.00	Primary payer payments		50,778	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		62,468,806	61.00
62.00	Deductibles billed to program beneficiaries		5,026,812	62.00
63.00	Coinsurance billed to program beneficiaries		231,644	63.00
64.00	Allowable bad debts (see instructions)		799,889	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		519,928	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		799,889	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		57,730,278	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		50,730	70.93
70.94	HRR adjustment amount (see instructions)		-322,227	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
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)		57,458,781	71.00
71.01	Sequestration adjustment (see instructions)		1,149,176	71.01
72.00	Interim payments		56,136,827	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)		172,778	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,540,000	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	326	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	25,753,594	2.00
3.00	PPS payments	25,520,976	3.00
4.00	Outlier payment (see instructions)	128,708	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.897	5.00
6.00	Line 2 times line 5	23,100,974	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	432,452	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	326	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,423	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,423	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)	1,423	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,097	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)	326	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)	26,082,136	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	231	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,973,987	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)	21,108,244	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	234,651	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)	21,342,895	30.00
31.00	Primary payer payments	7,184	31.00
32.00	Subtotal (line 30 minus line 31)	21,335,711	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)	659,511	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	428,682	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	659,511	36.00
37.00	Subtotal (see instructions)	21,764,393	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER PER PS&R	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)	21,764,393	40.00
40.01	Sequestration adjustment (see instructions)	435,288	40.01
41.00	Interim payments	21,562,278	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-233,173	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	907	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,676	2.00
3.00	PPS payments	2,633	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	34	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	907	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,203	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)	5,203	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)	5,203	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,296	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)	907	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)	2,667	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)	391	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)	3,183	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)	3,183	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,183	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	3,183	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)	3,183	40.00
40.01	Sequestration adjustment (see instructions)	64	40.01
41.00	Interim payments	2,783	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	336	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	476	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	73	2.00
3.00	PPS payments	376	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	1	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	476	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,734	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	2,734	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)	2,734	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,258	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)	476	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)	377	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	853	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)	853	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	853	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	853	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)	853	40.00
40.01	Sequestration adjustment (see instructions)	17	40.01
41.00	Interim payments	688	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	148	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,246	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,246	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	24,363	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)	24,363	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)	24,363	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	20,117	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)	4,246	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,246	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)	4,246	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	4,246	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	4,246	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,246	40.00
40.01	Sequestration adjustment (see instructions)	85	40.01
41.00	Interim payments	23,876	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-19,715	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 4/28/2017 12:14 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		56,991,198		21,459,480	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/12/2016	225,128	05/12/2016	102,798	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	09/27/2016	1,079,499		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)		-854,371		102,798	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)		56,136,827		21,562,278	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		172,778		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		233,173	6.02
7.00	Total Medicare program liability (see instructions)		56,309,605		21,329,105	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: 14-0015 | Component CCN: 14-S015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,259,090		2,783	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)		1,259,090		2,783	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		139,760		336	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,398,850		3,119	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: 14-0015 | Component CCN: 14-T015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,016,513		688	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/12/2016	20,544		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)		20,544		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,037,057		688	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		148	6.01
6.02	SETTLEMENT TO PROGRAM		19,674		0	6.02
7.00	Total Medicare program liability (see instructions)		5,017,383		836	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: 14-0015 Component CCN: 14-5643	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part I Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,447,448		23,876	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)		1,447,448		23,876	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		176,077		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		19,715	6.02
7.00	Total Medicare program liability (see instructions)		1,623,525		4,161	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: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 4/28/2017 12:14 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	11,183	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	25,449	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3,102	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	42,361	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	967,908,842	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	16,333,348	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)	27,471	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	27,471	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)	27,471	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-S015	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part II Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,511,283	1.00
2.00	Net IPF PPS Outlier Payments	8,257	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	30.609290	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,519,540	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,519,540	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,519,540	18.00
19.00	Deductibles	224,448	19.00
20.00	Subtotal (line 18 minus line 19)	1,295,092	20.00
21.00	Coinsurance	10,269	21.00
22.00	Subtotal (line 20 minus line 21)	1,284,823	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	123,463	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	80,251	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	123,463	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,365,074	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	62,324	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,427,398	31.00
31.01	Sequestration adjustment (see instructions)	28,548	31.01
32.00	Interim payments	1,259,090	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	139,760	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	8,257	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-T015	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part III Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,868,812	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0307	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	148,499	3.00
4.00	Outlier Payments	141,677	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	13.131148	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	5,158,988	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	5,158,988	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	5,158,988	19.00
20.00	Deductibles	24,388	20.00
21.00	Subtotal (line 19 minus line 20)	5,134,600	21.00
22.00	Coinsurance	19,964	22.00
23.00	Subtotal (line 21 minus line 22)	5,114,636	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	5,114,636	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	5,143	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	5,119,779	32.00
32.01	Sequestration adjustment (see instructions)	102,396	32.01
33.00	Interim payments	5,037,057	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-19,674	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	141,677	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0015 Component CCN: 14-5643	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,532,918	1.00
2.00	Routine service other pass through costs	169,894	2.00
3.00	Ancillary service other pass through costs	9,776	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,712,588	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	55,930	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,656,658	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,656,658	15.00
15.01	Sequestration adjustment (see instructions)	33,133	15.01
16.00	Interim payments	1,447,448	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	176,077	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-4 | Date/Time Prepared: 4/28/2017 12:14 am

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			19.50	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			19.50	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			17.01	6.00
7.00	Enter the lesser of line 5 or line 6			17.01	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	17.01	0.00	17.01	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	17.01	0.00	17.01	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	17.01	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	18.23	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	18.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	17.75	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	17.75	0.00		17.00
18.00	Per resident amount	84,649.94	0.00		18.00
19.00	Approved amount for resident costs	1,502,536	0	1,502,536	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,502,536	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	30,689	3,379		26.00
27.00	Total Inpatient Days (see instructions)	58,370	58,370		27.00
28.00	Ratio of inpatient days to total inpatient days	0.525767	0.057889		28.00
29.00	Program direct GME amount	789,984	86,980		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		12,290		30.00
31.00	Net Program direct GME amount			864,674	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet E-4 Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	1,979,036	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	70,862,391	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	50,778	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	70,811,613	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	26,385,968	42.00
43.00	Primary payer payments (see instructions)	12,381	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	26,373,587	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	97,185,200	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.728625	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.271375	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	864,674	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	630,023	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	234,651	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 4/28/2017 12:14 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	55,251,417	0	0	0	1.00
2.00	Temporary investments	132,068,570	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	195,123,238	0	0	0	4.00
5.00	Other receivable	7,801,926	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-140,364,746	0	0	0	6.00
7.00	Inventory	6,853,285	0	0	0	7.00
8.00	Prepaid expenses	4,766,289	0	0	0	8.00
9.00	Other current assets	179,407	0	0	0	9.00
10.00	Due from other funds	2,117,423	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	263,796,809	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	13,311,335	0	0	0	12.00
13.00	Land improvements	6,626,177	0	0	0	13.00
14.00	Accumulated depreciation	-4,155,595	0	0	0	14.00
15.00	Buildings	206,699,438	0	0	0	15.00
16.00	Accumulated depreciation	-57,710,059	0	0	0	16.00
17.00	Leasehold improvements	11,398,421	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	-31,056,276	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	144,752,339	0	0	0	23.00
24.00	Accumulated depreciation	-92,929,487	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	196,936,293	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	16,384,401	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	10,438,813	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,823,214	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	487,556,316	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	22,085,704	0	0	0	37.00
38.00	Salaries, wages, and fees payable	15,473,879	0	0	0	38.00
39.00	Payroll taxes payable	831,029	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,003,854	0	0	0	40.00
41.00	Deferred income	1,480,641	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	13,214,733	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	58,089,840	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	86,596,067	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	88,183,414	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	174,779,481	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	232,869,321	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	254,686,995				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)	254,686,995	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	487,556,316	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 4/28/2017 12:14 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		213,292,144		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		29,863,010				2.00
3.00	Total (sum of line 1 and line 2)		243,155,154		0		3.00
4.00	CONTRIBUTIONS	2,730,547		0		0	4.00
5.00	NET REAL AND UNREAL GAINS/LOSSES	4,920		0		0	5.00
6.00	PENSION LIABILITY ADJUSTMENT	11,178,212		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)		13,913,679		0		10.00
11.00	Subtotal (line 3 plus line 10)		257,068,833		0		11.00
12.00	NET ASSETS RELEASED	2,373,334		0		0	12.00
13.00	OTHER	8,504		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)		2,381,838		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		254,686,995		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	CONTRIBUTIONS		0			4.00
5.00	NET REAL AND UNREAL GAINS/LOSSES		0			5.00
6.00	PENSION LIABILITY ADJUSTMENT		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	NET ASSETS RELEASED		0			12.00
13.00	OTHER		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: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 4/28/2017 12:14 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	76,054,037		76,054,037	1.00
2.00	SUBPROVIDER - IPF	23,349,092		23,349,092	2.00
3.00	SUBPROVIDER - IRF	5,910,257		5,910,257	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,855,763		4,855,763	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)	110,169,149		110,169,149	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	34,382,382		34,382,382	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)	34,382,382		34,382,382	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	144,551,531		144,551,531	17.00
18.00	Ancillary services	388,565,767	516,405,450	904,971,217	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	847,527	847,527	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		7,206,803	7,206,803	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	48,083	3,736,954	3,785,037	26.00
27.00	NURSERY	3,389,850	0	3,389,850	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	536,555,231	528,196,734	1,064,751,965	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		321,332,498		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)		321,332,498		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0015 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 4/28/2017 12:14 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,064,751,965	1.00
2.00	Less contractual allowances and discounts on patients' accounts	736,901,847	2.00
3.00	Net patient revenues (line 1 minus line 2)	327,850,118	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	321,332,498	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,517,620	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	6,503,991	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	748,774	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,577,986	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	3,222,939	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	1,067,270	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	7,993,580	24.00
24.01	TRANSFERS	1,567,580	24.01
24.02	TRANSFERS	663,270	24.02
25.00	Total other income (sum of lines 6-24)	23,345,390	25.00
26.00	Total (line 5 plus line 25)	29,863,010	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	29,863,010	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0015 HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H Date/Time Prepared: 4/28/2017 12:14 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	482,051	0	0	0	0	482,051	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,242,325	0	153,502	0	678,446	2,074,273	6.00
7.00	Physical Therapy	871,486	0	69,347	0	306,495	1,247,328	7.00
8.00	Occupational Therapy	245,822	0	21,495	0	95,002	362,319	8.00
9.00	Speech Pathology	18,108	0	2,195	0	9,699	30,002	9.00
10.00	Medical Social Services	110,386	0	591	0	2,611	113,588	10.00
11.00	Home Health Aide	193,259	0	33,368	0	147,477	374,104	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	10,674	0	849	0	3,919	15,442	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,174,111	0	281,347	0	1,243,649	4,699,107	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	482,051	0	482,051			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	181	2,074,454	-300	2,074,154			6.00
7.00	Physical Therapy	0	1,247,328	0	1,247,328			7.00
8.00	Occupational Therapy	0	362,319	0	362,319			8.00
9.00	Speech Pathology	0	30,002	0	30,002			9.00
10.00	Medical Social Services	0	113,588	0	113,588			10.00
11.00	Home Health Aide	0	374,104	0	374,104			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	15,442	0	15,442			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	181	4,699,288	-300	4,698,988			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part I | Date/Time Prepared: 4/28/2017 12:14 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	482,051	0	0	0	0	482,051	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	2,074,154	0	0	0	0	2,074,154	6.00
7.00	Physical Therapy	1,247,328	0	0	0	0	1,247,328	7.00
8.00	Occupational Therapy	362,319	0	0	0	0	362,319	8.00
9.00	Speech Pathology	30,002	0	0	0	0	30,002	9.00
10.00	Medical Social Services	113,588	0	0	0	0	113,588	10.00
11.00	Home Health Aide	374,104	0	0	0	0	374,104	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	15,442	0	0	0	0	15,442	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	4,698,988	0	0	0	0	4,698,988	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	482,051		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	237,102	2,311,256	6.00
7.00	Physical Therapy	142,586	1,389,914	7.00
8.00	Occupational Therapy	41,418	403,737	8.00
9.00	Speech Pathology	3,430	33,432	9.00
10.00	Medical Social Services	12,985	126,573	10.00
11.00	Home Health Aide	42,765	416,869	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	1,765	17,207	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		4,698,988	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part II | Date/Time Prepared: 4/28/2017 12:14 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-482,051	4,216,937	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	2,074,154	6.00
7.00	Physical Therapy	0	0	0	0	0	1,247,328	7.00
8.00	Occupational Therapy	0	0	0	0	0	362,319	8.00
9.00	Speech Pathology	0	0	0	0	0	30,002	9.00
10.00	Medical Social Services	0	0	0	0	0	113,588	10.00
11.00	Home Health Aide	0	0	0	0	0	374,104	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	15,442	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-482,051	4,216,937	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		482,051	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.114313	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015 HHA CCN: 14-7031

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part I Date/Time Prepared: 4/28/2017 12:14 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	BUTLER BUILDING	OLD BLDG & FIXT	NEW BLDG & FIXT	14TH STREET	
		0	1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	0	0	3,719	1.00
2.00	Skilled Nursing Care	2,311,256	0	0	0	0	0	2.00
3.00	Physical Therapy	1,389,914	0	0	0	0	0	3.00
4.00	Occupational Therapy	403,737	0	0	0	0	0	4.00
5.00	Speech Pathology	33,432	0	0	0	0	0	5.00
6.00	Medical Social Services	126,573	0	0	0	0	0	6.00
7.00	Home Health Aide	416,869	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	17,207	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	4,698,988	0	0	0	0	3,719	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CAPITAL RELATED COSTS MOB PHASE I	BBC	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		1.05	1.06	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	7,222	83,566	94,507	32,945	1.00
2.00	Skilled Nursing Care	0	0	0	215,365	2,526,621	880,772	2.00
3.00	Physical Therapy	0	0	0	151,077	1,540,991	537,185	3.00
4.00	Occupational Therapy	0	0	0	42,615	446,352	155,597	4.00
5.00	Speech Pathology	0	0	0	3,139	36,571	12,749	5.00
6.00	Medical Social Services	0	0	0	19,136	145,709	50,794	6.00
7.00	Home Health Aide	0	0	0	33,503	450,372	156,998	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	1,850	19,057	6,643	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	7,222	550,251	5,260,180	1,833,683	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015 HHA CCN: 14-7031

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part I Date/Time Prepared: 4/28/2017 12:14 am

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	Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	76,647	0	43,320	0	0	719,452	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	76,647	0	43,320	0	0	719,452	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	PARAMED ED PRGM-RADIOLOGY	
		16.00	20.00	21.00	22.00	23.00	23.01	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0015 HHA CCN: 14-7031

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part I Date/Time Prepared: 4/28/2017 12:14 am

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	Cost Center Description	PARAMED ED PRGM-LABORATORY	PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		23.02	23.03	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	966,871	0	966,871		1.00
2.00	Skilled Nursing Care	0	0	3,407,393	0	3,407,393	472,914	2.00
3.00	Physical Therapy	0	0	2,078,176	0	2,078,176	288,430	3.00
4.00	Occupational Therapy	0	0	601,949	0	601,949	83,545	4.00
5.00	Speech Pathology	0	0	49,320	0	49,320	6,845	5.00
6.00	Medical Social Services	0	0	196,503	0	196,503	27,273	6.00
7.00	Home Health Aide	0	0	607,370	0	607,370	84,297	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	25,700	0	25,700	3,567	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	7,933,282	0	7,933,282	966,871	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.138790	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	3,880,307	2.00
3.00	Physical Therapy	2,366,606	3.00
4.00	Occupational Therapy	685,494	4.00
5.00	Speech Pathology	56,165	5.00
6.00	Medical Social Services	223,776	6.00
7.00	Home Health Aide	691,667	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	29,267	19.00
19.50	Telemedicine	0	19.50
20.00	Total (sum of lines 1-19) (2)	7,933,282	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part II | Date/Time Prepared: 4/28/2017 12:14 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	BUTLER BUILDING (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT (SQUARE FEET)	14TH STREET (SQUARE FEET)	MOB PHASE I (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	0	0	0	0	4,925	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	4,925	0	20.00
21.00	Total cost to be allocated	0	0	0	0	3,719	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.755127	0.000000	22.00

	Cost Center Description	CAPITAL RELATED COSTS BBC (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.06	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	0	7,296	482,051	0	94,507	4,925	1.00
2.00	Skilled Nursing Care	0	0	1,242,325	0	2,526,621	0	2.00
3.00	Physical Therapy	0	0	871,486	0	1,540,991	0	3.00
4.00	Occupational Therapy	0	0	245,822	0	446,352	0	4.00
5.00	Speech Pathology	0	0	18,108	0	36,571	0	5.00
6.00	Medical Social Services	0	0	110,386	0	145,709	0	6.00
7.00	Home Health Aide	0	0	193,259	0	450,372	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	10,674	0	19,057	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	7,296	3,174,111		5,260,180	4,925	20.00
21.00	Total cost to be allocated	0	7,222	550,251		1,833,683	76,647	21.00
22.00	Unit cost multiplier	0.000000	0.989857	0.173356		0.348597	15.562843	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part II | Date/Time Prepared: 4/28/2017 12:14 am

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		8.00	9.00	10.00	11.00	13.00	16.00	
1.00	Administrative and General	0	896	0	0	101,381	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	896	0	0	101,381	0	20.00
21.00	Total cost to be allocated	0	43,320	0	0	719,452	0	21.00
22.00	Unit cost multiplier	0.000000	48.348214	0.000000	0.000000	7.096517	0.000000	22.00

	Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	PARAMED ED PRGM-RADIOLOGY (ASSIGNED TIME)	PARAMED ED PRGM-LABORATORY (ASSIGNED TIME)	
		20.00	21.00	22.00	23.00	23.01	23.02	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0015
HHA CCN: 14-7031

Period:
From 10/01/2015
To 09/30/2016

Worksheet H-2
Part II
Date/Time Prepared:
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	Cost Center Description	PARAMED ED PRGM-PHARMACY (ASSIGNED TIME)		
		23.03		
1.00	Administrative and General	0		1.00
2.00	Skilled Nursing Care	0		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	0		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
19.50	Telemedicine	0		19.50
20.00	Total (sum of lines 1-19)	0		20.00
21.00	Total cost to be allocated	0		21.00
22.00	Unit cost multiplier	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 4/28/2017 12:14 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	3,880,307		3,880,307	27,001	143.71	1.00
2.00	Physical Therapy	3.00	2,366,606	0	2,366,606	12,351	191.61	2.00
3.00	Occupational Therapy	4.00	685,494	0	685,494	3,783	181.20	3.00
4.00	Speech Pathology	5.00	56,165	0	56,165	388	144.76	4.00
5.00	Medical Social Services	6.00	223,776		223,776	104	2,151.69	5.00
6.00	Home Health Aide	7.00	691,667		691,667	5,872	117.79	6.00
7.00	Total (sum of lines 1-6)		7,904,015	0	7,904,015	49,499		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	14,522			8.00
8.01	Skilled Nursing Care		99926	0	2,184			8.01
8.02	Skilled Nursing Care		50089	0	678			8.02
9.00	Physical Therapy		99914	0	8,066			9.00
9.01	Physical Therapy		99926	0	1,129			9.01
9.02	Physical Therapy		50089	0	252			9.02
10.00	Occupational Therapy		99914	0	2,472			10.00
10.01	Occupational Therapy		99926	0	248			10.01
10.02	Occupational Therapy		50089	0	102			10.02
11.00	Speech Pathology		99914	0	141			11.00
11.01	Speech Pathology		99926	0	74			11.01
11.02	Speech Pathology		50089	0	3			11.02
12.00	Medical Social Services		99914	0	58			12.00
12.01	Medical Social Services		99926	0	7			12.01
12.02	Medical Social Services		50089	0	1			12.02
13.00	Home Health Aide		99914	0	3,631			13.00
13.01	Home Health Aide		99926	0	1,008			13.01
13.02	Home Health Aide		50089	0	251			13.02
14.00	Total (sum of lines 8-13)			0	34,827			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	15,086	15,086	89,257	0.169018	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	17,384		0	2,498,255		1.00
2.00	Physical Therapy	0	9,447		0	1,810,140		2.00
3.00	Occupational Therapy	0	2,822		0	511,346		3.00
4.00	Speech Pathology	0	218		0	31,558		4.00
5.00	Medical Social Services	0	66		0	142,012		5.00
6.00	Home Health Aide	0	4,890		0	575,993		6.00
7.00	Total (sum of lines 1-6)	0	34,827		0	5,569,304		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015 HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I Date/Time Prepared: 4/28/2017 12:14 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	89,257	0	0	15,086	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	2,498,255	1.00
2.00	Physical Therapy	1,810,140	2.00
3.00	Occupational Therapy	511,346	3.00
4.00	Speech Pathology	31,558	4.00
5.00	Medical Social Services	142,012	5.00
6.00	Home Health Aide	575,993	6.00
7.00	Total (sum of lines 1-6)	5,569,304	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part II | Date/Time Prepared: 4/28/2017 12:14 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.547971	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.373321	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.377888	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.169017	89,257	15,086	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.174268	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 4/28/2017 12:14 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	5,354,151	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	5,354,151	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	5,354,151	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	5,197	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	-5,197	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	4,308,154	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	329,105	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	58,113	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	40,322	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	160,690	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	5,349	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	4,896,536	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	4,896,536	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	4,896,536	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	4,896,536	29.00
30.00	OTHER ADJUSTMENT	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	4,896,536	31.00
31.01	Sequestration adjustment (see instructions)	0	97,932	31.01
32.00	Interim payments (see instructions)	0	4,798,604	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0015 | HHA CCN: 14-7031 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-5 | Date/Time Prepared: 4/28/2017 12:14 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		4,798,604	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		4,798,604	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		4,798,604	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O | Date/Time Prepared: 4/28/2017 12:14 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	301,595	108,837	410,432	0	410,432	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	101,289	101,289	0	101,289	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	20,812	20,812	13.00
14.00	PHARMACY*	0	166,333	166,333	0	166,333	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*						16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	11,651	48,000	59,651	0	59,651	26.00
27.00	NURSE PRACTITIONER**	33,951	0	33,951	0	33,951	27.00
28.00	REGISTERED NURSE**	644,640	0	644,640	0	644,640	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	196,060	0	196,060	0	196,060	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	2,989	0	2,989	0	2,989	33.00
34.00	SPIRITUAL COUNSELING**	79,835	0	79,835	0	79,835	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	76,757	138,220	214,977	0	214,977	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	89,939	89,939	0	89,939	38.00
39.00	PATIENT TRANSPORTATION**	0	5,524	5,524	0	5,524	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	7,414	7,414	0	7,414	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	33,991	33,991	-42	33,949	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	76,391	0	76,391	0	76,391	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	1,423,869	699,547	2,123,416	20,770	2,144,186	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O | Date/Time Prepared: 4/28/2017 12:14 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	410,432		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	101,289		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	20,812		13.00
14.00	PHARMACY*	0	166,333		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)*				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	69,043	69,043		25.00
26.00	PHYSICIAN SERVICES**	-11,651	48,000		26.00
27.00	NURSE PRACTITIONER**	0	33,951		27.00
28.00	REGISTERED NURSE**	0	644,640		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	196,060		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	2,989		33.00
34.00	SPIRITUAL COUNSELING**	0	79,835		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	214,977		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	89,939		38.00
39.00	PATIENT TRANSPORTATION**	0	5,524		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	19,161	26,575		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	33,949		42.00
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	76,391		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	76,553	2,220,739		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0015 Hospice CCN: 14-1501 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-2 | Date/Time Prepared: 4/28/2017 12:14 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	11,651	48,000	59,651	0	59,651	26.00
27.00	NURSE PRACTITIONER	33,951	0	33,951	0	33,951	27.00
28.00	REGISTERED NURSE	626,129	0	626,129	0	626,129	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	196,060	0	196,060	0	196,060	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	78,656	0	78,656	0	78,656	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	76,674	138,220	214,894	0	214,894	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	89,939	89,939	0	89,939	38.00
39.00	PATIENT TRANSPORTATION	0	5,524	5,524	0	5,524	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	7,414	7,414	0	7,414	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	33,968	33,968	-42	33,926	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,023,121	323,065	1,346,186	-42	1,346,144	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	-11,651	48,000		26.00
27.00	NURSE PRACTITIONER	0	33,951		27.00
28.00	REGISTERED NURSE	0	626,129		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	196,060		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	78,656		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	214,894		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	89,939		38.00
39.00	PATIENT TRANSPORTATION	0	5,524		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	19,161	26,575		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	33,926		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	7,510	1,353,654		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-3 | Date/Time Prepared: 4/28/2017 12:14 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	553	0	553	0	553	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	56	0	56	0	56	33.00
34.00	SPIRITUAL COUNSELING	51	0	51	0	51	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	83	0	83	0	83	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	23	23	0	23	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	743	23	766	0	766	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	1,350	1,350		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	553		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	56		33.00
34.00	SPIRITUAL COUNSELING	0	51		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	83		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	23		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	1,350	2,116		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-4 | Date/Time Prepared: 4/28/2017 12:14 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	17,958	0	17,958	0	17,958	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	2,933	0	2,933	0	2,933	33.00
34.00	SPIRITUAL COUNSELING	1,128	0	1,128	0	1,128	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	22,019	0	22,019	0	22,019	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	67,693	67,693		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	17,958		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	2,933		33.00
34.00	SPIRITUAL COUNSELING	0	1,128		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	67,693	89,712		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0015 Hospice CCN: 14-1501

Period: From 10/01/2015 To 09/30/2016

Worksheet O-5

Date/Time Prepared: 4/28/2017 12:14 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	109,559	109,559	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	247,683	247,683	3.00
4.00	ADMINISTRATIVE & GENERAL	410,432	898,676	1,309,108	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	365,960	365,960	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	101,289		101,289	12.00
13.00	VOLUNTEER SERVICE COORDINATION	20,812		20,812	13.00
14.00	PHARMACY	166,333	0	166,333	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,353,654		1,353,654	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,116		2,116	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	89,712		89,712	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	76,391		76,391	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	2,220,739	1,659,328	3,880,067	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0015 Hospice CCN: 14-1501 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part I Date/Time Prepared: 4/28/2017 12:14 am

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	109,559		109,559			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	247,683	0	0	247,683		3.00
4.00	ADMINISTRATIVE & GENERAL	1,309,108	0	109,559	66,293	1,484,960	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	365,960	0	0	0	365,960	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	101,289	0	0	0	101,289	12.00
13.00	VOLUNTEER SERVICE COORDINATION	20,812	0	0	0	20,812	13.00
14.00	PHARMACY	166,333	0	0	0	166,333	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	37,450	0	0	0	37,450	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1,353,654			177,398	1,531,052	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2,116	0	0	130	2,246	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	89,712	0	0	3,862	93,574	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	76,391	0	0	0	76,391	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	3,880,067	0	109,559	247,683	3,880,067	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS | Provider CCN: 14-0015 Hospice CCN: 14-1501 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part I Date/Time Prepared: 4/28/2017 12:14 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	1,484,960					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	226,894	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	0	0		0		11.00
12.00	STAFF TRANSPORTATION	62,799	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	12,903	0		0		13.00
14.00	PHARMACY	103,126	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)	23,219	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	949,248					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,393	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	58,016	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	47,362	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	1,484,960	0	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2015 To 09/30/2016

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	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	592,854					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			164,088		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	33,715	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	584,079	0	0	161,660	33,216	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	399	0	0	110	23	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	8,376	0	0	2,318	476	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	592,854	0	0	164,088	33,715	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period: From 10/01/2015 To 09/30/2016

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	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	269,459					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		60,669			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	269,275	0	60,669		3,589,199	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	184	0	0	0	4,355	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	162,760	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		123,753	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	269,459	0	60,669	0	3,880,067	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period:
From 10/01/2015
To 09/30/2016

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Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		110,682				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,412,218			3.00
4.00	ADMINISTRATIVE & GENERAL	0	110,682	377,986	-1,484,960	2,395,107	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	365,960	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	101,289	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	20,812	13.00
14.00	PHARMACY	0	0	0	0	166,333	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	37,450	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			1,011,470	0	1,531,052	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	743	0	2,246	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	22,019	0	93,574	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	76,391	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	109,559	247,683		1,484,960	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.989854	0.175386		0.619997	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period:
From 10/01/2015
To 09/30/2016

Worksheet O-6
Part II
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Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		14,864	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					14,644	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	10	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	210	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0	0	592,854	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	39.885226	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period:
From 10/01/2015
To 09/30/2016

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	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	0					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			14,864			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	14,864		13.00
14.00	PHARMACY			0	0	14,654	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	14,644	14,644	14,644	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	10	10	10	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	210	210	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	164,088	33,715	269,459	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	11.039290	2.268232	18.388085	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0015
Hospice CCN: 14-1501

Period:
From 10/01/2015
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	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)		14,644			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	14,644			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	60,669	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	4.142925	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0015 Hospice CCN: 14-1501

Period: From 10/01/2015 To 09/30/2016

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	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.547971	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.373321	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.377888	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.174268	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.100217	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.169017	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.239121	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0015 | Hospice CCN: 14-1501 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-8 | Date/Time Prepared: 4/28/2017 12:14 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			3,589,199	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			14,644	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			245.10	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	13,309	348		9.00
10.00	Program cost (line 8 times line 9)	3,262,036	85,295		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			4,355	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			10	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			435.50	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	10	0		14.00
15.00	Program cost (line 13 times line 14)	4,355	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			162,760	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			210	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			775.05	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	163	17		19.00
20.00	Program cost (line 18 times line 19)	126,333	13,176		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,756,314	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			14,864	22.00
23.00	Average cost per diem (line 21 divided by line 22)			252.71	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0015	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,513,880	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	176,863	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)	118.26	3.00
4.00	Number of interns & residents (see instructions)	16.83	4.00
5.00	Indirect medical education percentage (see instructions)	4.10	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)	144,069	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	3,834,812	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 4/28/2017 12:14 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	157,705	0	157,705	0	157,705	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	184,850	0	184,850	0	184,850	9.00
10.00	Subtotal (sum of lines 1 through 9)	342,555	0	342,555	0	342,555	10.00
11.00	Physician Services Under Agreement	0	278,077	278,077	0	278,077	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	16,322	16,322	0	16,322	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	294,399	294,399	0	294,399	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	64,492	64,492	-995	63,497	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	64,492	64,492	-995	63,497	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	342,555	358,891	701,446	-995	700,451	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	88,000	88,000	0	88,000	29.00
30.00	Administrative Costs	99,418	39,359	138,777	0	138,777	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	99,418	127,359	226,777	0	226,777	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	441,973	486,250	928,223	-995	927,228	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-1 | Date/Time Prepared: 4/28/2017 12:14 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	157,705		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	184,850		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	342,555		10.00
11.00	Physician Services Under Agreement	0	278,077		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	2,869	19,191		13.00
14.00	Subtotal (sum of lines 11 through 13)	2,869	297,268		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	63,497		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	63,497		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,869	703,320		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-44,598	43,402		29.00
30.00	Administrative Costs	0	138,777		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-44,598	182,179		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-41,729	885,499		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES | Provider CCN: 14-0015 | Component CCN: 14-3422 | Period: From 10/01/2015 To 09/30/2016 | Worksheet M-2 | Date/Time Prepared: 4/28/2017 12:14 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC I Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.22	1,811	4,200	5,124		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.43	6,123	2,100	3,003		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.65	7,934		8,127	8,127	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.12	135			135	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.77	8,069			8,262	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					703,320	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					703,320	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					182,179	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					412,010	15.00
16.00	Total overhead (sum of lines 14 and 15)					594,189	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					594,189	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					594,189	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,297,509	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		1,297,509	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		47,899	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,249,610	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		8,262	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		8,262	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		151.25	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	80.44	81.32	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	605	1,745	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	48,666	141,903	11.00
12.00	Program covered visits for mental health services (from contractor records)	14	6	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	1,126	488	13.00
14.00	Limit adjustment for mental health services (see instructions)	1,126	488	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	192,183	16.00
16.01	Total program charges (see instructions)(from contractor's records)		495,596	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		700	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		271	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		124,849	16.04
16.05	Total program cost (see instructions)	0	125,120	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		35,851	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		91,809	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		125,120	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		29,767	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		154,887	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		154,887	26.00
26.01	Sequestration adjustment (see instructions)		3,098	26.01
27.00	Interim payments		121,847	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		29,942	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2015 To 09/30/2016	Worksheet M-4 Date/Time Prepared: 4/28/2017 12:14 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	342,555	342,555	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000383	0.005069	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	131	1,736	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	15,930	8,167	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	16,061	9,903	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	703,320	703,320	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	594,189	594,189	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.022836	0.014080	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	13,569	8,366	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	29,630	18,269	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	117	463	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	253.25	39.46	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	87	196	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	22,033	7,734	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		47,899	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		29,767	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0015 Component CCN: 14-3422	Period: From 10/01/2015 To 09/30/2016	Worksheet M-5 Date/Time Prepared: 4/28/2017 12:14 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		119,333	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		05/12/2016	2,514	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		2,514	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		121,847	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		29,942	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		151,789	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00