

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: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 4/26/2017 11:59 am
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 4/26/2017 Time: 11:59 am  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

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

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARGARET'S HOSPITAL ( 14-0143 ) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-9,543	169,538	366,524	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
200.00 Total	0	-9,543	169,538	366,524	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: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet S-2 Part I Date/Time Prepared: 4/24/2017 9:56 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 600 EAST FIRST ST	PO Box:						1.00		
2.00	City: SPRING VALLEY	State: IL	Zip Code: 61362	County: BUREAU				2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST. MARGARET'S HOSPITAL	140143	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. MARGARET'S HOSPITAL	14U143	99914		06/23/2003	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	ST. MARGARET'S HOSPITAL	141595	99914		07/07/1998				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	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)					1			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(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	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2 N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	993	0	0	0	5	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 4/24/2017 9:56 am			
		Urban/Rural S	Date of Geogr				
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00		
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1			37.00		
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.	10/01/2015	09/30/2016		38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00		
		V	XVII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
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		
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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			
64.00	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. 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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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.			N		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	
<b>Title V and XIX Services</b>						
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	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		
<b>Rural Providers</b>								
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00		
		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00		
					1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>								
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		
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00		
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	481,583		0		0		
					1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02		
119.00	DO NOT USE THIS LINE					119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		Y		120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00		
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		
<b>Transplant Center Information</b>								
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: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet S-2 Part I Date/Time Prepared: 4/24/2017 9:56 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	35H002				140.00	
		1.00	2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: SISTERS MARY OF THE PRESENTATION HC	Contractor's Name: NORIDIAN ADMIN SVC		Contractor's Number: 03001				141.00
142.00	Street: 1202 PAGE DR SW PO BOX 10007	PO Box:						142.00
143.00	City: FARGO	State: ND		Zip Code: 58106-0007				143.00
						1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00	
		1.00	2.00					
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00	
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00	
				Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC	N	N	N	N		161.00	
						1.00		
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N				165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
							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)						0168.00	
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)					0.25	169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 4/24/2017 9:56 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)		10/01/2015	09/30/2016	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. 1, 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		0171.00



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet S-2 Part II Date/Time Prepared: 4/24/2017 9:56 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					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	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	02/02/2017	Y	02/02/2017
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			Y		N	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0143

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 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:	PIP PYMTS WERE ENTERED AS PAYMENT.		Y	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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
<b>Provider-Based Physicians</b>						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
				Y/N	Date	
				1.00	2.00	
<b>Home Office Costs</b>						
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
				1.00	2.00	
<b>Cost Report Preparer Contact Information</b>						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DON		TROGLIO		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. MARGARET'S HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-664-1328		DTROGLIO@ABOUTSMG.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 4/24/2017 9:56 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF ACCOUNTING		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0143

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	57	20,862	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		57	20,862	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,196	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		63	23,058	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		63				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0143

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 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)	2,817	496	4,854			1.00
2.00 HMO and other (see instructions)	617	5				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	80	0	90			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)	2,897	496	4,944			7.00
8.00 INTENSIVE CARE UNIT	520	54	832			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		383	718			13.00
14.00 Total (see instructions)	3,417	933	6,494	0.00	537.20	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	7.67	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	544.87	27.00
28.00 Observation Bed Days		484	2,801			28.00
29.00 Ambulance Trips	459					29.00
30.00 Employee discount days (see instruction)			22			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	60	115			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: 14-0143

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	884	435	1,747	1.00
2.00 HMO and other (see instructions)				129	3		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		884	435	1,747	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	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: 14-0143

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	33,682,705	636,751	34,319,456	1,131,747.23	30.32
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		7,769,037	0	7,769,037	44,656.00	173.98
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,053,176	125,817	1,178,993	49,883.55	23.63
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		293,334	0	293,334	4,255.00	68.94
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		966,326	0	966,326	5,037.00	191.85
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		1,012,962	0	1,012,962	7,754.00	130.64
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		6,568,044	0	6,568,044		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		268,749	0	268,749		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		278,828	0	278,828		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		248,569	0	248,569		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	212,944	0	212,944	6,240.25	34.12
27.00	Administrative & General	5.00	2,813,247	-125,817	2,687,430	112,071.51	23.98

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0143

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		164,658	0	164,658	767.40	214.57	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	465,760	0	465,760	20,775.39	22.42	30.00
31.00	Laundry & Linen Service	8.00	0	37,395	37,395	3,004.49	12.45	31.00
32.00	Housekeeping	9.00	490,233	-37,395	452,838	35,278.85	12.84	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	781,948	-585,366	196,582	12,836.27	15.31	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	585,366	585,366	38,222.88	15.31	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,036,248	0	1,036,248	26,342.54	39.34	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	1,452,577	0	1,452,577	50,091.45	29.00	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: 14-0143

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
4/24/2017 9:56 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	26,078,326	636,751	26,715,077	1,087,858.63	24.56	1.00
2.00	Excluded area salaries (see instructions)	1,053,176	125,817	1,178,993	49,883.55	23.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)	25,025,150	510,934	25,536,084	1,037,975.08	24.60	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,272,622	0	2,272,622	17,046.00	133.32	4.00
5.00	Subtotal wage-related costs (see inst.)	6,816,613	0	6,816,613	0.00	26.69	5.00
6.00	Total (sum of lines 3 thru 5)	34,114,385	510,934	34,625,319	1,055,021.08	32.82	6.00
7.00	Total overhead cost (see instructions)	7,417,615	-125,817	7,291,798	305,631.03	23.86	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 4/24/2017 9:56 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		737,873	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
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
<b>HEALTH AND INSURANCE COST</b>				
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)		3,529,724	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		189,207	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		25,112	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		3,447	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		132,554	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		276,614	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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		1,685,910	17.00
18.00	Medicare Taxes - Employers Portion Only		484,908	18.00
19.00	Unemployment Insurance		25,725	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
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		24,548	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,115,622	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet S-3 Part V Date/Time Prepared: 4/24/2017 9:56 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital -Based SNF			8.00
9.00	Hospital -Based NF			9.00
10.00	Hospital -Based OLTC			10.00
11.00	Hospital -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital -Based Hospice	0	0	13.00
14.00	Hospital -Based Health Clinic RHC	0	0	14.00
15.00	Hospital -Based Health Clinic FQHC			15.00
16.00	Hospital -Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0143

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

Worksheet S-7

Date/Time Prepared:  
4/24/2017 9:56 am

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	0	0	0	16.00
17.00	RVA	0	0	0	17.00
18.00	RHC	0	0	0	18.00
19.00	RHB	0	0	0	19.00
20.00	RHA	0	0	0	20.00
21.00	RMC	0	4	4	21.00
22.00	RMB	0	0	0	22.00
23.00	RMA	0	3	3	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	26	26	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	15	15	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	4	4	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	4	4	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	0	0	0	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	5	5	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	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	15	15	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	4	4	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	0	0	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	0	0	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: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet S-7 Date/Time Prepared: 4/24/2017 9:56 am
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		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	80	80	200.00

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

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

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 14-0143 Hospice CCN: 14-1595	Period: From 10/01/2015 To 09/30/2016	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 4/24/2017 9:56 am
		Hospice I		

	Unduplicated Days	Hospice I				Total (sum of cols. 1, 2 & 5)		
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			All Other
		1.00	2.00	3.00	4.00			5.00
<b>PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015</b>								
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	
<b>Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015</b>								
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	
<b>PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015</b>						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	5,383	0	0	5,383	11.00
12.00	Hospice Inpatient Respite Care	15	0	0	15	12.00
13.00	Hospice General Inpatient Care	70	0	0	70	13.00
14.00	Total Hospice Days	5,468	0	0	5,468	14.00
<b>PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015</b>						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet S-10 Date/Time Prepared: 4/24/2017 9:56 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.331489	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		4,037,099	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		29,569,024	6.00
7.00	Medicaid cost (line 1 times line 6)		9,801,806	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		5,764,707	8.00
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>				
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
<b>Other state or local government indigent care program (see instructions for each line)</b>				
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
<b>Uncompensated care (see instructions for each line)</b>				
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		134,710	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		5,764,707	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)	564,608	2,198,652	2,763,260
21.00	Cost of patients approved for charity care (line 1 times line 20)	187,161	728,829	915,990
22.00	Partial payment by patients approved for charity care	129,778	309,940	439,718
23.00	Cost of charity care (line 21 minus line 22)	57,383	418,889	476,272
				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)		2,284,120	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		303,884	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		1,980,236	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		656,426	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,132,698	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,897,405	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,773,470	2,773,470	-66,932	2,706,538	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT		47,392	47,392	0	47,392	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,455,206	2,455,206	124,644	2,579,850	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	212,944	7,240,877	7,453,821	0	7,453,821	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,813,247	5,800,292	8,613,539	-160,557	8,452,982	5.00
7.00	00700	OPERATION OF PLANT	465,760	1,636,709	2,102,469	0	2,102,469	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	168,333	168,333	37,395	205,728	8.00
9.00	00900	HOUSEKEEPING	490,233	230,710	720,943	-37,395	683,548	9.00
10.00	01000	DIETARY	781,948	395,631	1,177,579	-881,536	296,043	10.00
11.00	01100	CAFETERIA	0	0	0	881,536	881,536	11.00
13.00	01300	NURSING ADMINISTRATION	1,036,248	85,489	1,121,737	0	1,121,737	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,452,577	264,889	1,717,466	0	1,717,466	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,330,279	1,288,397	3,618,676	-80,274	3,538,402	30.00
31.00	03100	INTENSIVE CARE UNIT	641,026	55,856	696,882	0	696,882	31.00
43.00	04300	NURSERY	89,100	182,379	271,479	0	271,479	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,974,554	3,872,029	5,846,583	0	5,846,583	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	313,299	71,991	385,290	80,274	465,564	52.00
53.00	05300	ANESTHESIOLOGY	0	1,334,454	1,334,454	0	1,334,454	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	801,885	1,483,050	2,284,935	0	2,284,935	54.00
54.01	05402	NUCLEAR MEDICINE	122,491	389,963	512,454	0	512,454	54.01
57.00	05700	CT SCAN	148,528	238,350	386,878	0	386,878	57.00
60.00	06000	LABORATORY	982,107	2,168,757	3,150,864	0	3,150,864	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	228,960	228,960	0	228,960	63.00
65.00	06500	RESPIRATORY THERAPY	413,756	76,945	490,701	0	490,701	65.00
66.00	06600	PHYSICAL THERAPY	1,248,266	138,056	1,386,322	0	1,386,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,290	2,901	152,191	0	152,191	67.00
68.00	06800	SPEECH PATHOLOGY	75,195	2,230	77,425	0	77,425	68.00
69.00	06900	ELECTROCARDIOLOGY	153,592	106,441	260,033	0	260,033	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56,711	54,536	111,247	0	111,247	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,329	178,725	223,054	75	223,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,126,929	2,126,929	0	2,126,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	709,918	1,943,754	2,653,672	-75	2,653,597	73.00
76.00	03020	SONOGRAPHY	173,459	353,999	527,458	0	527,458	76.00
76.01	03040	AUDIOLOGY	0	0	0	235,171	235,171	76.01
76.02	03160	CARDIAC REHAB	162,090	13,014	175,104	0	175,104	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	13,915,882	3,345,690	17,261,572	513,547	17,775,119	90.00
91.00	09100	EMERGENCY	870,815	1,671,926	2,542,741	0	2,542,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	242	597,428	597,670	0	597,670	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	836,375	836,375	-836,375	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	455,194	536,743	991,937	0	991,937	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,084,965	44,398,876	77,483,841	-190,502	77,293,339	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	32,689	3,855	36,544	0	36,544	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	49,651	16,595	66,246	0	66,246	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	1,649	1,649	0	1,649	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	238,008	351,610	589,618	0	589,618	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A

Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.19 07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20 07970 PARATRANSIT	0	0	0	162,414	162,414	194.20
194.21 07971 OCCUPATIONAL HEALTH	196,672	20,351	217,023	28,088	245,111	194.21
194.24 07974 SURGICAL ASSOCIATES	0	469	469	0	469	194.24
194.27 07977 MIDTOWN	0	0	0	0	0	194.27
194.28 07978 PAIN CLINIC	80,720	1,946	82,666	0	82,666	194.28
194.30 07980 WHC-PTON	0	0	0	0	0	194.30
194.31 07981 CFH	0	0	0	0	0	194.31
194.32 07982 PFS	0	0	0	0	0	194.32
200.00 TOTAL (SUM OF LINES 118-199)	33,682,705	44,795,351	78,478,056	0	78,478,056	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-38,558	2,667,980	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	47,392	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,307	2,582,157	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	88	88	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,319,446	6,134,375	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-347,015	8,105,967	5.00
7.00	00700	OPERATION OF PLANT	-1,800	2,100,669	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	205,728	8.00
9.00	00900	HOUSEKEEPING	0	683,548	9.00
10.00	01000	DIETARY	0	296,043	10.00
11.00	01100	CAFETERIA	-206,563	674,973	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,121,737	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,065	1,715,401	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-874,539	2,663,863	30.00
31.00	03100	INTENSIVE CARE UNIT	0	696,882	31.00
43.00	04300	NURSERY	-157,197	114,282	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	5,846,583	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	465,564	52.00
53.00	05300	ANESTHESIOLOGY	-1,118,169	216,285	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,284,935	54.00
54.01	05402	NUCLEAR MEDICINE	0	512,454	54.01
57.00	05700	CT SCAN	0	386,878	57.00
60.00	06000	LABORATORY	0	3,150,864	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	228,960	63.00
65.00	06500	RESPIRATORY THERAPY	0	490,701	65.00
66.00	06600	PHYSICAL THERAPY	-20,224	1,366,098	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	152,191	67.00
68.00	06800	SPEECH PATHOLOGY	0	77,425	68.00
69.00	06900	ELECTROCARDIOLOGY	-20,800	239,233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	111,247	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	223,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-85,000	2,041,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-310,254	2,343,343	73.00
76.00	03020	SONOGRAPHY	-2,514	524,944	76.00
76.01	03040	AUDIOLOGY	0	235,171	76.01
76.02	03160	CARDIAC REHAB	0	175,104	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	-7,784,416	9,990,703	90.00
91.00	09100	EMERGENCY	-1,207,317	1,335,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	597,670	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	991,937	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-13,493,482	63,799,857	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	36,544	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	194.02
194.03	07953	MANAGED CARE	0	66,246	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	1,649	194.05
194.08	07958	ENT	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	589,618	194.09
194.10	07960	PERU MALL	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	194.13
194.14	07964	HENRY	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	194.16
194.17	07967	OGLESBY MOB	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	194.19
194.20	07970	PARATRANSIT	0	162,414	194.20

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0143

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

Worksheet A  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
194.21	07971	OCCUPATIONAL HEALTH	0	245,111	194.21
194.24	07974	SURGICAL ASSOCIATES	0	469	194.24
194.27	07977	MIDTOWN	0	0	194.27
194.28	07978	PAIN CLINIC	0	82,666	194.28
194.30	07980	WHC-PTON	0	0	194.30
194.31	07981	CFH	0	0	194.31
194.32	07982	PFS	0	0	194.32
200.00		TOTAL (SUM OF LINES 118-199)	-13,493,482	64,984,574	200.00

RECLASSIFICATIONS

Provider CCN: 14-0143

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

Worksheet A-6

Date/Time Prepared:  
4/24/2017 9:56 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - IV COSTS FROM PHARMACY</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	75	1.00
	TOTALS		0	75	
<b>B - DIETARY RECLASS</b>					
1.00	CAFETERIA	11.00	585,366	296,170	1.00
	TOTALS		585,366	296,170	
<b>C - LAUNDRY SALARIES</b>					
1.00	LAUNDRY & LINEN SERVICE	8.00	37,395	0	1.00
	TOTALS		37,395	0	
<b>D - DEPRECIATION FOR OFF CAMPUS CLINICS</b>					
1.00	CLINIC	90.00	0	748,718	1.00
2.00	OCCUPATIONAL HEALTH	194.21	0	28,088	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	776,806	
<b>E - AUDIOLOGY COSTS</b>					
1.00	AUDIOLOGY	76.01	0	235,171	1.00
	TOTALS		0	235,171	
<b>F - INTEREST EXPENSE ON EQUIPMENT</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	124,644	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,857	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	709,874	3.00
	TOTALS		0	836,375	
<b>G - PARATRANSIT COSTS</b>					
1.00	PARATRANSIT	194.20	125,817	36,597	1.00
	TOTALS		125,817	36,597	
<b>H - LABOR AND DELIVERY SALARIES</b>					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	80,274	0	1.00
	TOTALS		80,274	0	
<b>I - TO RECLASS EMPLOYED HOSPITALIST</b>					
1.00	ADULTS & PEDIATRICS	30.00	636,751	0	1.00
	TOTALS		636,751	0	
500.00	Grand Total: Increases		1,465,603	2,181,194	500.00

RECLASSIFICATIONS

Provider CCN: 14-0143

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

Worksheet A-6

Date/Time Prepared:  
4/24/2017 9:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - IV COSTS FROM PHARMACY</b>							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	75	0		1.00
	TOTALS		0	75			
<b>B - DIETARY RECLASS</b>							
1.00	DIETARY	10.00	585,366	296,170	0		1.00
	TOTALS		585,366	296,170			
<b>C - LAUNDRY SALARIES</b>							
1.00	HOUSEKEEPING	9.00	37,395	0	0		1.00
	TOTALS		37,395	0			
<b>D - DEPRECIATION FOR OFF CAMPUS CLINICS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	776,806	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	776,806			
<b>E - AUDIOLOGY COSTS</b>							
1.00	CLINIC	90.00	0	235,171	0		1.00
	TOTALS		0	235,171			
<b>F - INTEREST EXPENSE ON EQUIPMENT</b>							
1.00	INTEREST EXPENSE	113.00	0	836,375	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	836,375			
<b>G - PARATRANSIT COSTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	125,817	36,597	0		1.00
	TOTALS		125,817	36,597			
<b>H - LABOR AND DELIVERY SALARIES</b>							
1.00	ADULTS & PEDIATRICS	30.00	80,274	0	0		1.00
	TOTALS		80,274	0			
<b>I - TO RECLASS EMPLOYED HOSPITALIST</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	636,751	0		1.00
	TOTALS		0	636,751			
500.00	Grand Total: Decreases		828,852	2,817,945			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,762,328	0	0	0	1.00
2.00	Land Improvements	2,600,159	149,519	0	149,519	2.00
3.00	Buildings and Fixtures	62,166,113	7,270,640	0	7,270,640	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	25,384,633	2,051,404	0	2,051,404	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	92,913,233	9,471,563	0	9,471,563	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	92,913,233	9,471,563	0	9,471,563	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,762,328	0			1.00
2.00	Land Improvements	2,749,678	0			2.00
3.00	Buildings and Fixtures	69,436,753	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	27,436,037	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	102,384,796	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	102,384,796	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,773,470	0	0	0	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	47,392	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,455,206	0	0	0	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	5,276,068	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,773,470				1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	47,392				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,455,206				2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	5,276,068				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0143

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	73,865,464	0	73,865,464	0.721449	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	1,083,295	0	1,083,295	0.010581	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	27,425,358	0	27,425,358	0.267866	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	10,679	0	10,679	0.000104	0	2.01
3.00	Total (sum of lines 1-2)	102,384,796	0	102,384,796	0.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,996,664	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	47,392	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,457,513	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	88	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,501,657	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	671,316	0	0	0	2,667,980	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	47,392	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	124,644	0	0	0	2,582,157	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	88	2.01
3.00	Total (sum of lines 1-2)	795,960	0	0	0	5,297,617	3.00



ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0143

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

Worksheet A-8

Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-37,803	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
1.01 Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)			OLD CAP REL COSTS-BLDG & FIXT		1.01	0	1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	2.00
2.01 Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)			OLD CAP REL COSTS-MVBLE EQUIP		2.01	0	2.01
3.00 Investment income - other (chapter 2)		0			0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-45,277	ADMINISTRATIVE & GENERAL		5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-1,800	OPERATION OF PLANT		7.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-11,396,523				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	-68,773				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-206,563	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-310,254	DRUGS CHARGED TO PATIENTS		73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-2,065	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY		65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY		66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW-SNF		114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
26.01 Depreciation - OLD CAP REL COSTS-BLDG & FIXT			OLD CAP REL COSTS-BLDG & FIXT		1.01	0	26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	27.00
27.01 Depreciation - OLD CAP REL COSTS-MVBLE EQUIP			OLD CAP REL COSTS-MVBLE EQUIP		2.01	0	27.01
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***		19.00		28.00
29.00 Physicians' assistant					0.00	0	29.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.				
			Cost Center	Line #					
			1.00	2.00		3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00				0		0.00		0	33.00
33.01	OUTSIDE PHYSICAL THERAPY	B	-20,224		PHYSICAL THERAPY	66.00		0	33.01
33.03	OB COMMISSIONS	B	-53		ADMINISTRATIVE & GENERAL	5.00		0	33.03
33.04	HOME OFFICE OPERATING INTEREST INCOM	B	-755		NEW CAP REL COSTS-BLDG & FIXT	1.00		11	33.04
33.06	PATIENT PHONES	A	-22,926		ADMINISTRATIVE & GENERAL	5.00		0	33.06
33.07	PATIENT PHONES DEPRECIATION	A	-11,210		NEW CAP REL COSTS-MVBLE EQUIP	2.00		9	33.07
33.10	MISC INCOME	B	-878		ADMINISTRATIVE & GENERAL	5.00		0	33.10
33.11	PHYSICIAN RECRUITMENT	A	-134,216		ADMINISTRATIVE & GENERAL	5.00		0	33.11
33.12	EMPLOYEE HEALTH	A	-1,040,618		EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.12
33.13	PHYSICIAN RECRUITMENT - CLINIC	A	-4,499		CLINIC	90.00		0	33.13
33.15	ADMIN COSTS FOR POB	A	17		ADMINISTRATIVE & GENERAL	5.00		0	33.15
33.16			0			0.00		0	33.16
33.17	LOBBYING PORTION OF IHHA DUES	A	-28,820		ADMINISTRATIVE & GENERAL	5.00		0	33.17
33.18			0			0.00		0	33.18
34.00	MISC REVENUE	B	-32,484		ADMINISTRATIVE & GENERAL	5.00		0	34.00
35.00	HOSPITALIST RECEPTIONIST & OTHER EXP	A	-42,758		ADULTS & PEDIATRICS	30.00		0	35.00
36.00	MISC REVENUE	B	-85,000		IMPL. DEV. CHARGED TO PATIENTS	72.00		0	36.00
37.00			0			0.00		0	37.00
38.00			0			0.00		0	38.00
39.00			0			0.00		0	39.00
40.00			0			0.00		0	40.00
41.00			0			0.00		0	41.00
42.00			0			0.00		0	42.00
43.00			0			0.00		0	43.00
44.00			0			0.00		0	44.00
45.00			0			0.00		0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,493,482						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: 14-0143

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

Worksheet A-8-1

Date/Time Prepared:  
4/24/2017 9:56 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,346,574	1,424,952 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SISTERS SALARIES	0	4,000 2.00
3.00	2.01	OLD CAP REL COSTS-MVBLE EQUI	OLD CAPITAL COSTS	88	0 3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	NEW CAPITAL COSTS	13,517	0 4.00
5.00	0		0	1,360,179	1,428,952 5.00

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

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

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

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

6.00	B		0.00	SRS OF MARY OF THE PRES	100.00	6.00
7.00	G	SMP HEALTH CORP	0.00	SMP HEALTH CORP	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				100.00

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

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

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

Provider CCN: 14-0143

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

Worksheet A-8-1

Date/Time Prepared:  
4/24/2017 9:56 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-78,378	0		1.00
2.00	-4,000	0		2.00
3.00	88	9		3.00
4.00	13,517	9		4.00
5.00	-68,773			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

6.00	RELIGIOUS COMMUNITY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0143

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

Worksheet A-8-2

Date/Time Prepared:  
4/24/2017 9:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	1,155,000	977,298	177,702	239,400	320	1.00
2.00	91.00	EMERGENCY	1,525,472	881,723	643,749	179,000	3,697	2.00
3.00	43.00	NURSERY	157,197	157,197	0	0	0	3.00
4.00	60.00	LABORATORY	35,000	0	35,000	260,300	520	4.00
5.00	69.00	ELECTROCARDIOLOGY	20,800	20,800	0	0	0	5.00
6.00	76.00	SONOGRAPHY	2,514	2,514	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	771,785	763,406	8,379	211,500	22	7.00
8.00	30.00	ADULTS & PEDIATRICS	126,496	0	126,496	211,500	632	8.00
9.00	90.00	CLINIC	7,769,037	7,769,037	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	278,828	278,828	0	0	0	10.00
11.00	90.00	CLINIC	10,880	10,880	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	10,000	0	10,000	211,500	200	12.00
200.00			11,863,009	10,861,683	1,001,326		5,391	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	36,831	1,842	0	0	0	1.00
2.00	91.00	EMERGENCY	318,155	15,908	0	0	0	2.00
3.00	43.00	NURSERY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	65,075	3,254	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.00	SONOGRAPHY	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	2,237	112	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	64,263	3,213	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	20,337	1,017	0	0	0	12.00
200.00			506,898	25,346	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	53.00	ANESTHESIOLOGY	0	36,831	140,871	1,118,169	1.00
2.00	91.00	EMERGENCY	0	318,155	325,594	1,207,317	2.00
3.00	43.00	NURSERY	0	0	0	157,197	3.00
4.00	60.00	LABORATORY	0	65,075	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	20,800	5.00
6.00	76.00	SONOGRAPHY	0	0	0	2,514	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	2,237	6,142	769,548	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	64,263	62,233	62,233	8.00
9.00	90.00	CLINIC	0	0	0	7,769,037	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	278,828	10.00
11.00	90.00	CLINIC	0	0	0	10,880	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	0	20,337	0	0	12.00
200.00			0	506,898	534,840	11,396,523	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
		0	1.00	1.01	2.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,667,980	2,667,980				1.00
1.01 00101 OLD CAP REL COSTS-BLDG & FIXT	47,392	0	47,392			1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	2,582,157			2,582,157		2.00
2.01 00201 OLD CAP REL COSTS-MVBLE EQUIP	88			0	88	2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	6,134,375	8,928	159	0	0	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	8,105,967	1,028,810	18,275	1,048,086	88	5.00
7.00 00700 OPERATION OF PLANT	2,100,669	242,188	4,302	47,571	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	205,728	6,409	114	0	0	8.00
9.00 00900 HOUSEKEEPING	683,548	25,581	454	4,365	0	9.00
10.00 01000 DIETARY	296,043	65,828	1,169	26,517	0	10.00
11.00 01100 CAFETERIA	674,973	21,876	389	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	1,121,737	26,428	469	2,659	0	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,715,401	33,863	602	41,747	0	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	2,663,863	186,959	3,321	131,335	0	30.00
31.00 03100 INTENSIVE CARE UNIT	696,882	41,128	731	17,268	0	31.00
43.00 04300 NURSERY	114,282	9,856	175	51,999	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	5,846,583	221,814	3,940	392,241	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	465,564	4,964	88	14,577	0	52.00
53.00 05300 ANESTHESIOLOGY	216,285	3,721	66	10,111	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,284,935	64,698	1,149	158,041	0	54.00
54.01 05402 NUCLEAR MEDICINE	512,454	16,935	301	92,079	0	54.01
57.00 05700 CT SCAN	386,878	5,247	93	152,432	0	57.00
60.00 06000 LABORATORY	3,150,864	31,554	560	45,002	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	228,960	1,889	34	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	490,701	9,444	168	18,517	0	65.00
66.00 06600 PHYSICAL THERAPY	1,366,098	84,410	1,499	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	152,191	315	6	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	77,425	1,421	25	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	239,233	1,066	19	14,967	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	111,247	10,752	191	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	223,129	62,850	1,116	9,847	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,041,929	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2,343,343	23,086	410	16,592	0	73.00
76.00 03020 SONOGRAPHY	524,944	4,319	77	42,073	0	76.00
76.01 03040 AUDIOLOGY	235,171	0	0	0	0	76.01
76.02 03160 CARDIAC REHAB	175,104	12,036	214	7,236	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	9,990,703	136,904	2,432	158,642	0	90.00
91.00 09100 EMERGENCY	1,335,424	79,131	1,406	66,656	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	597,670	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
116.00 11600 HOSPICE	991,937	7,862	140	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,799,857	2,482,272	44,094	2,570,560	88 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,776	191	0	0	190.00
194.00 07950 ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01 07951 CONGREGATE LIVING	36,544	107,150	1,903	0	0	194.01
194.02 07952 VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03 07953 MANAGED CARE	66,246	0	0	0	0	194.03
194.04 07954 RENTAL AREA/PPOS	0	44,373	788	0	0	194.04
194.05 07955 SPECIALTY CLINICS	1,649	0	0	1,567	0	194.05
194.08 07958 ENT	0	0	0	0	0	194.08
194.09 07959 DURABLE MEDICAL EQUIPMENT	589,618	23,409	416	4,612	0	194.09
194.10 07960 PERU MALL	0	0	0	0	0	194.10
194.12 07962 FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13 07963 WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14 07964 HENRY	0	0	0	0	0	194.14
194.16 07966 SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
		1.00	1.01	2.00	2.01	
194.17 07967 OGLESBY MP OB	0	0	0	0	0	194.17
194.18 07968 FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19 07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20 07970 PARATRANSIT	162,414	0	0	0	0	194.20
194.21 07971 OCCUPATIONAL HEALTH	245,111	0	0	0	0	194.21
194.24 07974 SURGICAL ASSOCIATES	469	0	0	0	0	194.24
194.27 07977 MIDTOWN	0	0	0	5,418	0	194.27
194.28 07978 PAIN CLINIC	82,666	0	0	0	0	194.28
194.30 07980 WHC-PTON	0	0	0	0	0	194.30
194.31 07981 CFH	0	0	0	0	0	194.31
194.32 07982 PFS	0	0	0	0	0	194.32
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)	64,984,574	2,667,980	47,392	2,582,157	88	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet B Part I Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,143,462					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	627,596	10,828,822	10,828,822			5.00
7.00	00700	OPERATION OF PLANT	108,769	2,503,499	500,592	3,004,091		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,733	220,984	44,187	13,871	279,042	8.00
9.00	00900	HOUSEKEEPING	105,751	819,699	163,905	55,363		9.00
10.00	01000	DIETARY	45,908	435,465	87,074	142,469		10.00
11.00	01100	CAFETERIA	136,701	833,939	166,752	47,344		11.00
13.00	01300	NURSING ADMINISTRATION	241,995	1,393,288	278,598	57,197		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	339,220	2,130,833	426,075	73,287		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	667,019	3,652,497	730,342	404,625	181,471	30.00
31.00	03100	INTENSIVE CARE UNIT	149,699	905,708	181,103	89,010	14,873	31.00
43.00	04300	NURSERY	20,808	197,120	39,416	21,331	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	461,118	6,925,696	1,384,841	480,061	29,578	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,911	577,104	115,396	10,744	0	52.00
53.00	05300	ANESTHESIOLOGY	0	230,183	46,027	8,054	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	187,264	2,696,087	539,101	140,023	18,612	54.00
54.01	05402	NUCLEAR MEDICINE	28,605	650,374	130,047	36,652	0	54.01
57.00	05700	CT SCAN	34,686	579,336	115,842	11,356	3,711	57.00
60.00	06000	LABORATORY	229,351	3,457,331	691,318	68,291	139	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	230,883	46,167	4,088	0	63.00
65.00	06500	RESPIRATORY THERAPY	96,624	615,454	123,064	20,440	544	65.00
66.00	06600	PHYSICAL THERAPY	291,508	1,743,515	348,628	182,685	14,873	66.00
67.00	06700	OCCUPATIONAL THERAPY	34,864	187,376	37,467	681	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,560	96,431	19,282	3,075	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,868	291,153	58,218	2,306	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,244	135,434	27,081	23,270	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,352	307,294	61,446	136,022	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,041,929	408,298	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	165,787	2,549,218	509,734	49,965	0	73.00
76.00	03020	SONOGRAPHY	40,508	611,921	122,358	9,347	0	76.00
76.01	03040	AUDIOLOGY	0	235,171	47,024	0	0	76.01
76.02	03160	CARDIAC REHAB	37,853	232,443	46,479	26,048	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,435,468	11,724,149	2,344,326	296,293	0	90.00
91.00	09100	EMERGENCY	203,361	1,685,978	337,123	171,260	14,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	57	597,727	119,520	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	106,301	1,106,240	221,200	17,016	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,974,489	63,430,281	10,518,031	2,602,174	278,674	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,967	2,193	23,323	0	190.00
194.00	07950	PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	7,634	153,231	30,640	231,898	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	11,595	77,841	15,565	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	45,161	9,030	96,033	0	194.04
194.05	07955	SPECIALTY CLINICS	0	3,216	643	0	368	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	55,582	673,637	134,698	50,663	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MOB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	29,382	191,796	38,351	0	0	194.20



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4.00	4A	5.00	7.00	8.00	
194.21	07971 OCCUPATIONAL HEALTH	45,929	291,040	58,195	0	0	194.21
194.24	07974 SURGICAL ASSOCIATES	0	469	94	0	0	194.24
194.27	07977 MIDTOWN	0	5,418	1,083	0	0	194.27
194.28	07978 PAIN CLINIC	18,851	101,517	20,299	0	0	194.28
194.30	07980 WHC-PTON	0	0	0	0	0	194.30
194.31	07981 CFH	0	0	0	0	0	194.31
194.32	07982 PFS	0	0	0	0	0	194.32
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	6,143,462	64,984,574	10,828,822	3,004,091	279,042	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet B Part I Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	1,038,967					9.00
10.00	01000	DIETARY	51,594	716,602				10.00
11.00	01100	CAFETERIA	41,145	0	1,089,180			11.00
13.00	01300	NURSING ADMINISTRATION	30,940	0	47,001	1,807,024		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,532	0	138,093	0	2,830,820	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	397,066	464,029	206,565	733,946	146,276	30.00
31.00	03100	INTENSIVE CARE UNIT	51,160	99,875	46,119	163,865	24,112	31.00
43.00	04300	NURSERY	4,695	0	12,478	44,389	9,989	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	82,724	33	155,818	553,571	456,925	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,735	0	24,030	85,390	14,066	52.00
53.00	05300	ANESTHESIOLOGY	841	0	0	0	84,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,750	0	65,343	0	184,289	54.00
54.01	05402	NUCLEAR MEDICINE	1,846	0	9,347	0	33,539	54.01
57.00	05700	CT SCAN	1,846	0	6,173	0	211,853	57.00
60.00	06000	LABORATORY	20,708	0	88,358	0	415,308	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,198	0	0	0	5,769	63.00
65.00	06500	RESPIRATORY THERAPY	4,994	0	27,381	0	42,976	65.00
66.00	06600	PHYSICAL THERAPY	10,313	0	0	0	116,228	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	12,415	67.00
68.00	06800	SPEECH PATHOLOGY	1,846	0	0	0	5,082	68.00
69.00	06900	ELECTROCARDIOLOGY	3,230	0	11,287	0	61,831	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	733	0	6,173	733	18,194	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,994	0	6,261	0	132,942	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	51,977	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,708	0	35,890	0	93,378	73.00
76.00	03020	SONOGRAPHY	1,846	0	10,009	0	84,759	76.00
76.01	03040	AUDIOLOGY	1,846	0	0	0	6,148	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	12,713	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	77,865	0	90,710	90.00
91.00	09100	EMERGENCY	20,708	0	63,579	225,863	119,250	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	8,171	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	33,818	0	41,528	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	871,998	563,937	1,071,588	1,807,024	2,484,729	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,846	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	85,434	194.00
194.01	07951	CONGREGATE LIVING	0	152,665	3,748	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	35,672	194.02
194.03	07953	MANAGED CARE	0	0	3,527	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	165,123	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	5,184	194.05
194.08	07958	ENT	0	0	0	0	22,886	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	9,051	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	45,092	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	41,198	194.13
194.14	07964	HENRY	0	0	0	0	1,524	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	6,609	194.16
194.17	07967	OGLESBY MOB	0	0	0	0	1,750	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	27,607	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	6,544	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	6,916,817	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,575,825	0	31.00
43.00	04300	NURSERY	0	329,418	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	10,069,247	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	847,465	0	52.00
53.00	05300	ANESTHESIOLOGY	0	369,406	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,674,205	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	861,805	0	54.01
57.00	05700	CT SCAN	0	930,117	0	57.00
60.00	06000	LABORATORY	0	4,741,453	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	289,105	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	834,853	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,416,242	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	237,939	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	125,716	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	428,025	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	210,885	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	648,959	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,502,204	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,258,893	0	73.00
76.00	03020	SONOGRAPHY	0	840,240	0	76.00
76.01	03040	AUDIOLOGY	0	290,189	0	76.01
76.02	03160	CARDIAC REHAB	0	317,683	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000	CLINIC	0	14,533,343	0	90.00
91.00	09100	EMERGENCY	0	2,638,634	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	725,418	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	0	1,419,802	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	62,033,888	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,329	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	85,434	0	194.00
194.01	07951	CONGREGATE LIVING	0	572,182	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	35,672	0	194.02
194.03	07953	MANAGED CARE	0	96,933	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	315,347	0	194.04
194.05	07955	SPECIALTY CLINICS	0	9,411	0	194.05
194.08	07958	ENT	0	22,886	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	868,049	0	194.09
194.10	07960	PERU MALL	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	45,092	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	41,198	0	194.13
194.14	07964	HENRY	0	1,524	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	6,609	0	194.16
194.17	07967	OGLESBY MP OB	0	1,750	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	27,607	0	194.18

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0143

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
194.19	07969 GRANVILLE CLINIC	0	6,544	0	6,544	194.19
194.20	07970 PARATRANSIT	0	230,147	0	230,147	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	364,828	0	364,828	194.21
194.24	07974 SURGICAL ASSOCIATES	0	563	0	563	194.24
194.27	07977 MIDDLETOWN	0	45,586	0	45,586	194.27
194.28	07978 PAIN CLINIC	0	122,475	0	122,475	194.28
194.30	07980 WHC-PTON	0	0	0	0	194.30
194.31	07981 CFH	0	12,450	0	12,450	194.31
194.32	07982 PFS	0	70	0	70	194.32
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	64,984,574	0	64,984,574	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			1.00	1.01	2.00	2.01	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100					1.00	
1.01	00101					1.01	
2.00	00200					2.00	
2.01	00201					2.01	
4.00	00400	0	8,928	159	0	4.00	
5.00	00500	16,074	1,028,810	18,275	1,048,086	88 5.00	
7.00	00700	1,474	242,188	4,302	47,571	0 7.00	
8.00	00800	0	6,409	114	0	0 8.00	
9.00	00900	3,420	25,581	454	4,365	0 9.00	
10.00	01000	0	65,828	1,169	26,517	0 10.00	
11.00	01100	0	21,876	389	0	0 11.00	
13.00	01300	0	26,428	469	2,659	0 13.00	
16.00	01600	0	33,863	602	41,747	0 16.00	
17.00	01700	0	0	0	0	0 17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	21,944	186,959	3,321	131,335	0 30.00	
31.00	03100	6,456	41,128	731	17,268	0 31.00	
43.00	04300	0	9,856	175	51,999	0 43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	147,765	221,814	3,940	392,241	0 50.00	
52.00	05200	0	4,964	88	14,577	0 52.00	
53.00	05300	28,056	3,721	66	10,111	0 53.00	
54.00	05400	384,395	64,698	1,149	158,041	0 54.00	
54.01	05402	0	16,935	301	92,079	0 54.01	
57.00	05700	0	5,247	93	152,432	0 57.00	
60.00	06000	0	31,554	560	45,002	0 60.00	
60.01	06001	0	0	0	0	0 60.01	
63.00	06300	0	1,889	34	0	0 63.00	
65.00	06500	9,041	9,444	168	18,517	0 65.00	
66.00	06600	20,220	84,410	1,499	0	0 66.00	
67.00	06700	0	315	6	0	0 67.00	
68.00	06800	0	1,421	25	0	0 68.00	
69.00	06900	0	1,066	19	14,967	0 69.00	
70.00	07000	0	10,752	191	0	0 70.00	
71.00	07100	0	62,850	1,116	9,847	0 71.00	
72.00	07200	0	0	0	0	0 72.00	
73.00	07300	16,956	23,086	410	16,592	0 73.00	
76.00	03020	0	4,319	77	42,073	0 76.00	
76.01	03040	0	0	0	0	0 76.01	
76.02	03160	0	12,036	214	7,236	0 76.02	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0 88.00	
90.00	09000	0	136,904	2,432	158,642	0 90.00	
91.00	09100	10,080	79,131	1,406	66,656	0 91.00	
92.00	09200	0	0	0	0	0 92.00	
93.00	04040	0	0	0	0	0 93.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	0 95.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	113.00	
114.00	11400	0	0	0	0	114.00	
116.00	11600	37,177	7,862	140	0	0 116.00	
118.00		703,058	2,482,272	44,094	2,570,560	88 118.00	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	10,776	191	0	0 190.00	
194.00	07950	0	0	0	0	0 194.00	
194.01	07951	0	107,150	1,903	0	0 194.01	
194.02	07952	0	0	0	0	0 194.02	
194.03	07953	0	0	0	0	0 194.03	
194.04	07954	0	44,373	788	0	0 194.04	
194.05	07955	0	0	0	1,567	0 194.05	
194.08	07958	0	0	0	0	0 194.08	
194.09	07959	0	23,409	416	4,612	0 194.09	
194.10	07960	0	0	0	0	0 194.10	
194.12	07962	0	0	0	0	0 194.12	
194.13	07963	0	0	0	0	0 194.13	
194.14	07964	0	0	0	0	0 194.14	
194.16	07966	0	0	0	0	0 194.16	
194.17	07967	0	0	0	0	0 194.17	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0143

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
		1.00	1.01	2.00	2.01	
194.18 07968 FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19 07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20 07970 PARATRANSIT	0	0	0	0	0	194.20
194.21 07971 OCCUPATIONAL HEALTH	0	0	0	0	0	194.21
194.24 07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27 07977 MIDTOWN	0	0	0	5,418	0	194.27
194.28 07978 PAIN CLINIC	0	0	0	0	0	194.28
194.30 07980 WHC-PTON	0	0	0	0	0	194.30
194.31 07981 CFH	0	0	0	0	0	194.31
194.32 07982 PFS	0	0	0	0	0	194.32
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)	703,058	2,667,980	47,392	2,582,157	88	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet B Part II Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	2A	4.00	5.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,087	9,087			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,111,333	927	2,112,260		5.00
7.00 00700	OPERATION OF PLANT	295,535	161	97,644	393,340	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	6,523	13	8,619	1,816	16,971
9.00 00900	HOUSEKEEPING	33,820	156	31,971	7,249	0
10.00 01000	DIETARY	93,514	68	16,984	18,654	0
11.00 01100	CAFETERIA	22,265	202	32,526	6,199	0
13.00 01300	NURSING ADMINISTRATION	29,556	358	54,342	7,489	0
16.00 01600	MEDICAL RECORDS & LIBRARY	76,212	501	83,109	9,596	0
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	343,559	985	142,458	52,980	11,036
31.00 03100	INTENSIVE CARE UNIT	65,583	221	35,325	11,655	905
43.00 04300	NURSERY	62,030	31	7,688	2,793	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	765,760	681	270,123	62,853	1,799
52.00 05200	DELIVERY ROOM & LABOR ROOM	19,629	136	22,509	1,407	0
53.00 05300	ANESTHESIOLOGY	41,954	0	8,978	1,055	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	608,283	277	105,155	18,334	1,132
54.01 05402	NUCLEAR MEDICINE	109,315	42	25,367	4,799	0
57.00 05700	CT SCAN	157,772	51	22,596	1,487	226
60.00 06000	LABORATORY	77,116	339	134,846	8,942	8
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,923	0	9,005	535	0
65.00 06500	RESPIRATORY THERAPY	37,170	143	24,005	2,676	33
66.00 06600	PHYSICAL THERAPY	106,129	431	68,002	23,920	905
67.00 06700	OCCUPATIONAL THERAPY	321	52	7,308	89	0
68.00 06800	SPEECH PATHOLOGY	1,446	26	3,761	403	0
69.00 06900	ELECTROCARDIOLOGY	16,052	53	11,356	302	0
70.00 07000	ELECTROENCEPHALOGRAPHY	10,943	20	5,282	3,047	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,813	15	11,985	17,810	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	79,641	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	57,044	245	99,427	6,542	0
76.00 03020	SONOGRAPHY	46,469	60	23,867	1,224	0
76.01 03040	AUDIOLOGY	0	0	9,172	0	0
76.02 03160	CARDIAC REHAB	19,486	56	9,066	3,411	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00 09000	CLINIC	297,978	2,131	457,305	38,795	0
91.00 09100	EMERGENCY	157,273	300	65,758	22,424	905
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				
93.00 04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	23,313	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
116.00 11600	HOSPICE	45,179	157	43,147	2,228	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,800,072	8,838	2,051,640	340,714	16,949
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,967	0	428	3,054	0
194.00 07950	ER PROFESSIONAL CHARGES	0	0	0	0	0
194.01 07951	CONGREGATE LIVING	109,053	11	5,976	30,364	0
194.02 07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0
194.03 07953	MANAGED CARE	0	17	3,036	0	0
194.04 07954	RENTAL AREA/PPOS	45,161	0	1,761	12,574	0
194.05 07955	SPECIALTY CLINICS	1,567	0	125	0	22
194.08 07958	ENT	0	0	0	0	0
194.09 07959	DURABLE MEDICAL EQUIPMENT	28,437	82	26,274	6,634	0
194.10 07960	PERU MALL	0	0	0	0	0
194.12 07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0
194.13 07963	WOMEN'S HEALTH CENTER	0	0	0	0	0
194.14 07964	HENRY	0	0	0	0	0
194.16 07966	SPRING VALLEY CLINIC	0	0	0	0	0
194.17 07967	OGLESBY MOB	0	0	0	0	0
194.18 07968	FAMILY HEALTH CENTER	0	0	0	0	0
194.19 07969	GRANVILLE CLINIC	0	0	0	0	0
194.20 07970	PARATRANSIT	0	43	7,481	0	0



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet B Part II Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		2A	4.00	5.00	7.00	8.00	
194.21	07971 OCCUPATIONAL HEALTH	0	68	11,351	0	0	194.21
194.24	07974 SURGICAL ASSOCIATES	0	0	18	0	0	194.24
194.27	07977 MIDTOWN	5,418	0	211	0	0	194.27
194.28	07978 PAIN CLINIC	0	28	3,959	0	0	194.28
194.30	07980 WHC-PTON	0	0	0	0	0	194.30
194.31	07981 CFH	0	0	0	0	0	194.31
194.32	07982 PFS	0	0	0	0	0	194.32
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	6,000,675	9,087	2,112,260	393,340	16,971	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet B Part II Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	73,196					9.00
10.00	01000	DIETARY	3,635	132,855				10.00
11.00	01100	CAFETERIA	2,899	0	64,091			11.00
13.00	01300	NURSING ADMINISTRATION	2,180	0	2,766	96,691		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,405	0	8,126	0	181,949	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	27,972	86,030	12,155	39,272	9,396	30.00
31.00	03100	INTENSIVE CARE UNIT	3,604	18,516	2,714	8,768	1,549	31.00
43.00	04300	NURSERY	331	0	734	2,375	642	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	5,828	6	9,169	29,621	29,457	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,461	0	1,414	4,569	904	52.00
53.00	05300	ANESTHESIOLOGY	59	0	0	0	5,415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,166	0	3,845	0	11,838	54.00
54.01	05402	NUCLEAR MEDICINE	130	0	550	0	2,154	54.01
57.00	05700	CT SCAN	130	0	363	0	13,609	57.00
60.00	06000	LABORATORY	1,459	0	5,199	0	26,678	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	155	0	0	0	371	63.00
65.00	06500	RESPIRATORY THERAPY	352	0	1,611	0	2,761	65.00
66.00	06600	PHYSICAL THERAPY	727	0	0	0	7,466	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	798	67.00
68.00	06800	SPEECH PATHOLOGY	130	0	0	0	326	68.00
69.00	06900	ELECTROCARDIOLOGY	228	0	664	0	3,972	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	52	0	363	0	1,169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	352	0	368	0	8,540	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,339	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,459	0	2,112	0	5,998	73.00
76.00	03020	SONOGRAPHY	130	0	589	0	5,445	76.00
76.01	03040	AUDIOLOGY	130	0	0	0	395	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	817	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	4,582	0	5,827	90.00
91.00	09100	EMERGENCY	1,459	0	3,741	12,086	7,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	525	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	1,990	0	2,668	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,433	104,552	63,055	96,691	159,719	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	130	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	5,488	194.00
194.01	07951	CONGREGATE LIVING	0	28,303	221	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	2,291	194.02
194.03	07953	MANAGED CARE	0	0	208	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	11,633	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	333	194.05
194.08	07958	ENT	0	0	0	0	1,470	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	581	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	2,897	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	2,646	194.13
194.14	07964	HENRY	0	0	0	0	98	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	425	194.16
194.17	07967	OGLESBY MOB	0	0	0	0	112	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	1,773	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	420	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0143			Period: From 10/01/2015 To 09/30/2016		Worksheet B Part II Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY		
		9.00	10.00	11.00	13.00	16.00		
194.21	07971 OCCUPATIONAL HEALTH	0	0	607	0	339	194.21	
194.24	07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24	
194.27	07977 MIDTOWN	0	0	0	0	2,511	194.27	
194.28	07978 PAIN CLINIC	0	0	0	0	42	194.28	
194.30	07980 WHC-PTON	0	0	0	0	0	194.30	
194.31	07981 CFH	0	0	0	0	800	194.31	
194.32	07982 PFS	0	0	0	0	4	194.32	
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)	73,196	132,855	64,091	96,691	181,949	202.00	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet B Part II Date/Time Prepared: 4/24/2017 9:56 am
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		17.00	24.00	25.00	26.00
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	725,843	30.00
31.00	03100	INTENSIVE CARE UNIT	0	148,840	31.00
43.00	04300	NURSERY	0	76,624	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,175,297	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52,029	52.00
53.00	05300	ANESTHESIOLOGY	0	57,461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	751,030	54.00
54.01	05402	NUCLEAR MEDICINE	0	142,357	54.01
57.00	05700	CT SCAN	0	196,234	57.00
60.00	06000	LABORATORY	0	254,587	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,989	63.00
65.00	06500	RESPIRATORY THERAPY	0	68,751	65.00
66.00	06600	PHYSICAL THERAPY	0	207,580	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,568	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,092	68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,627	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	20,876	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	112,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	82,980	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	172,827	73.00
76.00	03020	SONOGRAPHY	0	77,784	76.00
76.01	03040	AUDIOLOGY	0	9,697	76.01
76.02	03160	CARDIAC REHAB	0	32,836	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	806,618	90.00
91.00	09100	EMERGENCY	0	271,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	23,838	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE	0	95,369	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,623,223	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,579	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	5,488	194.00
194.01	07951	CONGREGATE LIVING	0	173,928	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	2,291	194.02
194.03	07953	MANAGED CARE	0	3,261	194.03
194.04	07954	RENTAL AREA/PPOS	0	71,129	194.04
194.05	07955	SPECIALTY CLINICS	0	2,047	194.05
194.08	07958	ENT	0	1,470	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	62,008	194.09
194.10	07960	PERU MALL	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	2,897	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	2,646	194.13
194.14	07964	HENRY	0	98	194.14
194.16	07966	SPRING VALLEY CLINIC	0	425	194.16
194.17	07967	OGLESBY MP OB	0	112	194.17
194.18	07968	FAMILY HEALTH CENTER	0	1,773	194.18

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet B Part II Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
194.19	07969 GRANVILLE CLINIC	0	420	0	420		194.19
194.20	07970 PARATRANSIT	0	7,524	0	7,524		194.20
194.21	07971 OCCUPATIONAL HEALTH	0	12,365	0	12,365		194.21
194.24	07974 SURGICAL ASSOCIATES	0	18	0	18		194.24
194.27	07977 MIDDLETOWN	0	8,140	0	8,140		194.27
194.28	07978 PAIN CLINIC	0	4,029	0	4,029		194.28
194.30	07980 WHC-PTON	0	0	0	0		194.30
194.31	07981 CFH	0	800	0	800		194.31
194.32	07982 PFS	0	4	0	4		194.32
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	6,000,675	0	6,000,675		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
		NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
		1.00	1.01	2.00	2.01		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	330,517				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	330,517			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,455,208		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP			0	95	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,106	1,106	0	0	26,306,964
5.00	00500	ADMINISTRATIVE & GENERAL	127,452	127,452	996,557	95	2,687,430
7.00	00700	OPERATION OF PLANT	30,003	30,003	45,232	0	465,760
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	37,395
9.00	00900	HOUSEKEEPING	3,169	3,169	4,150	0	452,838
10.00	01000	DIETARY	8,155	8,155	25,213	0	196,582
11.00	01100	CAFETERIA	2,710	2,710	0	0	585,366
13.00	01300	NURSING ADMINISTRATION	3,274	3,274	2,528	0	1,036,248
16.00	01600	MEDICAL RECORDS & LIBRARY	4,195	4,195	39,695	0	1,452,577
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	23,161	23,161	124,878	0	2,856,245
31.00	03100	INTENSIVE CARE UNIT	5,095	5,095	16,419	0	641,026
43.00	04300	NURSERY	1,221	1,221	49,443	0	89,100
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	27,479	27,479	372,957	0	1,974,554
52.00	05200	DELIVERY ROOM & LABOR ROOM	615	615	13,860	0	393,573
53.00	05300	ANESTHESIOLOGY	461	461	9,614	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,015	8,015	150,271	0	801,885
54.01	05402	NUCLEAR MEDICINE	2,098	2,098	87,552	0	122,491
57.00	05700	CT SCAN	650	650	144,938	0	148,528
60.00	06000	LABORATORY	3,909	3,909	42,790	0	982,107
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	234	234	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,170	1,170	17,607	0	413,756
66.00	06600	PHYSICAL THERAPY	10,457	10,457	0	0	1,248,266
67.00	06700	OCCUPATIONAL THERAPY	39	39	0	0	149,290
68.00	06800	SPEECH PATHOLOGY	176	176	0	0	75,195
69.00	06900	ELECTROCARDIOLOGY	132	132	14,231	0	153,592
70.00	07000	ELECTROENCEPHALOGRAPHY	1,332	1,332	0	0	56,711
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,786	7,786	9,363	0	44,329
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,860	2,860	15,776	0	709,918
76.00	03020	SONOGRAPHY	535	535	40,005	0	173,459
76.01	03040	AUDIOLOGY	0	0	0	0	0
76.02	03160	CARDIAC REHAB	1,491	1,491	6,880	0	162,090
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	16,960	16,960	150,843	0	6,146,845
91.00	09100	EMERGENCY	9,803	9,803	63,379	0	870,815
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	242
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
116.00	11600	HOSPICE	974	974	0	0	455,194
118.00		SUBTOTALS (SUM OF LINES 1-117)	307,511	307,511	2,444,181	95	25,583,407
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,335	1,335	0	0	0
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0
194.01	07951	CONGREGATE LIVING	13,274	13,274	0	0	32,689
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0
194.03	07953	MANAGED CARE	0	0	0	0	49,651
194.04	07954	RENTAL AREA/PPOS	5,497	5,497	0	0	0
194.05	07955	SPECIALTY CLINICS	0	0	1,490	0	0
194.08	07958	ENT	0	0	0	0	0
194.09	07959	DURABLE MEDICAL EQUIPMENT	2,900	2,900	4,385	0	238,008
194.10	07960	PERU MALL	0	0	0	0	0
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0
194.14	07964	HENRY	0	0	0	0	0
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
	NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)		
	1.00	1.01	2.00	2.01		
194.17 07967 OGLESBY MP OB	0	0	0	0	0	194.17
194.18 07968 FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19 07969 GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20 07970 PARATRANSIT	0	0	0	0	125,817	194.20
194.21 07971 OCCUPATIONAL HEALTH	0	0	0	0	196,672	194.21
194.24 07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27 07977 MIDTOWN	0	0	5,152	0	0	194.27
194.28 07978 PAIN CLINIC	0	0	0	0	80,720	194.28
194.30 07980 WHC-PTON	0	0	0	0	0	194.30
194.31 07981 CFH	0	0	0	0	0	194.31
194.32 07982 PFS	0	0	0	0	0	194.32
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)	2,667,980	47,392	2,582,157	88	6,143,462	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	8.072142	0.143387	1.051706	0.926316	0.233530	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)					9,087	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)					0.000345	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5A	5.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-10,828,822	54,155,752			5.00
7.00	00700	OPERATION OF PLANT	0	2,503,499	171,956		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	220,984	794	270,106	8.00
9.00	00900	HOUSEKEEPING	0	819,699	3,169	0	38,281
10.00	01000	DIETARY	0	435,465	8,155	0	1,901
11.00	01100	CAFETERIA	0	833,939	2,710	0	1,516
13.00	01300	NURSING ADMINISTRATION	0	1,393,288	3,274	0	1,140
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,130,833	4,195	0	2,304
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	3,652,497	23,161	175,658	14,630
31.00	03100	INTENSIVE CARE UNIT	0	905,708	5,095	14,397	1,885
43.00	04300	NURSERY	0	197,120	1,221	0	173
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	6,925,696	27,479	28,631	3,048
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	577,104	615	0	764
53.00	05300	ANESTHESIOLOGY	0	230,183	461	0	31
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,696,087	8,015	18,016	1,133
54.01	05402	NUCLEAR MEDICINE	0	650,374	2,098	0	68
57.00	05700	CT SCAN	0	579,336	650	3,592	68
60.00	06000	LABORATORY	0	3,457,331	3,909	135	763
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	230,883	234	0	81
65.00	06500	RESPIRATORY THERAPY	0	615,454	1,170	527	184
66.00	06600	PHYSICAL THERAPY	0	1,743,515	10,457	14,397	380
67.00	06700	OCCUPATIONAL THERAPY	0	187,376	39	0	0
68.00	06800	SPEECH PATHOLOGY	0	96,431	176	0	68
69.00	06900	ELECTROCARDIOLOGY	0	291,153	132	0	119
70.00	07000	ELECTROENCEPHALOGRAPHY	0	135,434	1,332	0	27
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	307,294	7,786	0	184
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,041,929	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,549,218	2,860	0	763
76.00	03020	SONOGRAPHY	0	611,921	535	0	68
76.01	03040	AUDIOLOGY	0	235,171	0	0	68
76.02	03160	CARDIAC REHAB	0	232,443	1,491	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	0	11,724,149	16,960	0	0
91.00	09100	EMERGENCY	0	1,685,978	9,803	14,397	763
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	597,727	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	1,106,240	974	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	-10,828,822	52,601,459	148,950	269,750	32,129
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,967	1,335	0	68
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0
194.01	07951	CONGREGATE LIVING	0	153,231	13,274	0	0
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0
194.03	07953	MANAGED CARE	0	77,841	0	0	0
194.04	07954	RENTAL AREA/PPOS	0	45,161	5,497	0	6,084
194.05	07955	SPECIALTY CLINICS	0	3,216	0	356	0
194.08	07958	ENT	0	0	0	0	0
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	673,637	2,900	0	0
194.10	07960	PERU MALL	0	0	0	0	0
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0
194.14	07964	HENRY	0	0	0	0	0
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0
194.17	07967	OGLESBY MOB	0	0	0	0	0
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)		
		5A	5.00	7.00	8.00	9.00		
194.20	07970	PARATRANSIT	0	191,796	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	291,040	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	469	0	0	0	194.24
194.27	07977	MIDTOWN	0	5,418	0	0	0	194.27
194.28	07978	PAIN CLINIC	0	101,517	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		10,828,822	3,004,091	279,042	1,038,967	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.199957	17.470114	1.033083	27.140540	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		2,112,260	393,340	16,971	73,196	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.039003	2.287446	0.062831	1.912071	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE  (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	21,611					10.00
11.00	01100	0	24,703				11.00
13.00	01300	0	1,066	239,936			13.00
16.00	01600	0	3,132	0	214,444,326		16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	13,994	4,685	97,453	11,080,683	0	30.00
31.00	03100	3,012	1,046	21,758	1,826,507	0	31.00
43.00	04300	0	283	5,894	756,660	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1	3,534	73,503	34,617,644	0	50.00
52.00	05200	0	545	11,338	1,065,538	0	52.00
53.00	05300	0	0	0	6,385,969	0	53.00
54.00	05400	0	1,482	0	13,960,215	0	54.00
54.01	05402	0	212	0	2,540,659	0	54.01
57.00	05700	0	140	0	16,048,287	0	57.00
60.00	06000	0	2,004	0	31,460,307	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	436,975	0	63.00
65.00	06500	0	621	0	3,255,528	0	65.00
66.00	06600	0	0	0	8,804,503	0	66.00
67.00	06700	0	0	0	940,449	0	67.00
68.00	06800	0	0	0	384,938	0	68.00
69.00	06900	0	256	0	4,683,783	0	69.00
70.00	07000	0	140	0	1,378,193	0	70.00
71.00	07100	0	142	0	10,070,569	0	71.00
72.00	07200	0	0	0	3,937,388	0	72.00
73.00	07300	0	814	0	7,073,581	0	73.00
76.00	03020	0	227	0	6,420,657	0	76.00
76.01	03040	0	0	0	465,737	0	76.01
76.02	03160	0	0	0	963,020	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
90.00	09000	0	1,766	0	6,871,479	0	90.00
91.00	09100	0	1,442	29,990	9,033,430	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	618,933	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
116.00	11600	0	767	0	3,145,837	0	116.00
118.00		17,007	24,304	239,936	188,227,469	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	6,471,758	0	194.00
194.01	07951	4,604	85	0	0	0	194.01
194.02	07952	0	0	0	2,702,196	0	194.02
194.03	07953	0	80	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	392,678	0	194.05
194.08	07958	0	0	0	1,733,646	0	194.08
194.09	07959	0	0	0	685,638	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.12	07962	0	0	0	3,415,781	0	194.12
194.13	07963	0	0	0	3,120,855	0	194.13
194.14	07964	0	0	0	115,431	0	194.14
194.16	07966	0	0	0	500,624	0	194.16
194.17	07967	0	0	0	132,531	0	194.17
194.18	07968	0	0	0	2,091,289	0	194.18

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0143

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

Worksheet B-1

Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		10.00	11.00	13.00	16.00	17.00	
194.19	07969 GRANVILLE CLINIC	0	0	0	495,691	0	194.19
194.20	07970 PARATRANSIT	0	0	0	0	0	194.20
194.21	07971 OCCUPATIONAL HEALTH	0	234	0	399,665	0	194.21
194.24	07974 SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977 MIDDTOWN	0	0	0	2,960,738	0	194.27
194.28	07978 PAIN CLINIC	0	0	0	49,927	0	194.28
194.30	07980 WHC-PTON	0	0	0	0	0	194.30
194.31	07981 CFH	0	0	0	943,105	0	194.31
194.32	07982 PFS	0	0	0	5,304	0	194.32
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)	716,602	1,089,180	1,807,024	2,830,820	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	33.159132	44.091001	7.531275	0.013201	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	132,855	64,091	96,691	181,949	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.147564	2.594462	0.402987	0.000848	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		6,916,817	68,375	6,985,192	30.00	
31.00	03100 INTENSIVE CARE UNIT		1,575,825	0	1,575,825	31.00	
43.00	04300 NURSERY		329,418	0	329,418	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		10,069,247	0	10,069,247	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		847,465	0	847,465	52.00	
53.00	05300 ANESTHESIOLOGY		369,406	140,871	510,277	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,674,205	0	3,674,205	54.00	
54.01	05402 NUCLEAR MEDICINE		861,805	0	861,805	54.01	
57.00	05700 CT SCAN		930,117	0	930,117	57.00	
60.00	06000 LABORATORY		4,741,453	0	4,741,453	60.00	
60.01	06001 BLOOD LABORATORY		0	0	0	60.01	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		289,105	0	289,105	63.00	
65.00	06500 RESPIRATORY THERAPY	0	834,853	0	834,853	65.00	
66.00	06600 PHYSICAL THERAPY	0	2,416,242	0	2,416,242	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	237,939	0	237,939	67.00	
68.00	06800 SPEECH PATHOLOGY	0	125,716	0	125,716	68.00	
69.00	06900 ELECTROCARDIOLOGY		428,025	0	428,025	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		210,885	0	210,885	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		648,959	0	648,959	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		2,502,204	0	2,502,204	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		3,258,893	0	3,258,893	73.00	
76.00	03020 SONOGRAPHY		840,240	0	840,240	76.00	
76.01	03040 AUDIOLOGY		290,189	0	290,189	76.01	
76.02	03160 CARDIAC REHAB		317,683	0	317,683	76.02	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00	
90.00	09000 CLINIC		14,533,343	0	14,533,343	90.00	
91.00	09100 EMERGENCY		2,638,634	325,594	2,964,228	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,548,266	0	2,548,266	92.00	
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER		0	0	0	93.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES		725,418	0	725,418	95.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE					113.00	
114.00	11400 UTILIZATION REVIEW-SNF					114.00	
116.00	11600 HOSPICE		1,419,802		1,419,802	116.00	
200.00	Subtotal (see instructions)	0	64,582,154	534,840	65,116,994	200.00	
201.00	Less Observation Beds		2,548,266		2,548,266	201.00	
202.00	Total (see instructions)	0	62,033,888	534,840	62,568,728	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	6,564,798		6,564,798		30.00
31.00	03100	INTENSIVE CARE UNIT	1,820,207		1,820,207		31.00
43.00	04300	NURSERY	751,123		751,123		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	6,670,958	27,661,536	34,332,494	0.293286	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	928,738	128,983	1,057,721	0.801218	52.00
53.00	05300	ANESTHESIOLOGY	1,832,310	4,496,114	6,328,424	0.058373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,212,057	12,659,214	13,871,271	0.264879	54.00
54.01	05402	NUCLEAR MEDICINE	100,075	2,425,459	2,525,534	0.341237	54.01
57.00	05700	CT SCAN	1,623,053	14,327,305	15,950,358	0.058313	57.00
60.00	06000	LABORATORY	5,718,435	25,577,781	31,296,216	0.151502	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	227,813	208,108	435,921	0.663205	63.00
65.00	06500	RESPIRATORY THERAPY	2,321,479	924,839	3,246,318	0.257169	65.00
66.00	06600	PHYSICAL THERAPY	767,113	7,986,275	8,753,388	0.276035	66.00
67.00	06700	OCCUPATIONAL THERAPY	112,745	822,108	934,853	0.254520	67.00
68.00	06800	SPEECH PATHOLOGY	34,438	349,140	383,578	0.327746	68.00
69.00	06900	ELECTROCARDIOLOGY	1,550,652	3,117,325	4,667,977	0.091694	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,854	1,362,625	1,365,479	0.154440	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,143,243	3,899,398	10,042,641	0.064620	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,470,413	466,975	3,937,388	0.635498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,710,314	4,306,536	7,016,850	0.464438	73.00
76.00	03020	SONOGRAPHY	758,385	5,624,373	6,382,758	0.131642	76.00
76.01	03040	AUDIOLOGY	0	465,737	465,737	0.623075	76.01
76.02	03160	CARDIAC REHAB	7,662	949,616	957,278	0.331861	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	46,000	6,769,431	6,815,431	2.132417	90.00
91.00	09100	EMERGENCY	1,240,382	7,753,656	8,994,038	0.293376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	921,665	3,555,619	4,477,284	0.569154	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	616,800	616,800	1.176099	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	3,145,157	3,145,157		116.00
200.00		Subtotal (see instructions)	47,536,912	139,600,110	187,137,022		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	47,536,912	139,600,110	187,137,022		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prepared: 4/24/2017 9:56 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.293286		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.801218		52.00
53.00	05300 ANESTHESIOLOGY	0.080633		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.264879		54.00
54.01	05402 NUCLEAR MEDICINE	0.341237		54.01
57.00	05700 CT SCAN	0.058313		57.00
60.00	06000 LABORATORY	0.151502		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.663205		63.00
65.00	06500 RESPIRATORY THERAPY	0.257169		65.00
66.00	06600 PHYSICAL THERAPY	0.276035		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.254520		67.00
68.00	06800 SPEECH PATHOLOGY	0.327746		68.00
69.00	06900 ELECTROCARDIOLOGY	0.091694		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.154440		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064620		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.635498		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.464438		73.00
76.00	03020 SONOGRAPHY	0.131642		76.00
76.01	03040 AUDIOLOGY	0.623075		76.01
76.02	03160 CARDIAC REHAB	0.331861		76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	2.132417		90.00
91.00	09100 EMERGENCY	0.329577		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.569154		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	1.176099		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	6,916,817		6,916,817	68,375	6,985,192	30.00
31.00	03100 INTENSIVE CARE UNIT	1,575,825		1,575,825	0	1,575,825	31.00
43.00	04300 NURSERY	329,418		329,418	0	329,418	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	10,069,247		10,069,247	0	10,069,247	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	847,465		847,465	0	847,465	52.00
53.00	05300 ANESTHESIOLOGY	369,406		369,406	140,871	510,277	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,674,205		3,674,205	0	3,674,205	54.00
54.01	05402 NUCLEAR MEDICINE	861,805		861,805	0	861,805	54.01
57.00	05700 CT SCAN	930,117		930,117	0	930,117	57.00
60.00	06000 LABORATORY	4,741,453		4,741,453	0	4,741,453	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	289,105		289,105	0	289,105	63.00
65.00	06500 RESPIRATORY THERAPY	834,853	0	834,853	0	834,853	65.00
66.00	06600 PHYSICAL THERAPY	2,416,242	0	2,416,242	0	2,416,242	66.00
67.00	06700 OCCUPATIONAL THERAPY	237,939	0	237,939	0	237,939	67.00
68.00	06800 SPEECH PATHOLOGY	125,716	0	125,716	0	125,716	68.00
69.00	06900 ELECTROCARDIOLOGY	428,025		428,025	0	428,025	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	210,885		210,885	0	210,885	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	648,959		648,959	0	648,959	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,502,204		2,502,204	0	2,502,204	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,258,893		3,258,893	0	3,258,893	73.00
76.00	03020 SONOGRAPHY	840,240		840,240	0	840,240	76.00
76.01	03040 AUDIOLOGY	290,189		290,189	0	290,189	76.01
76.02	03160 CARDIAC REHAB	317,683		317,683	0	317,683	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000 CLINIC	14,533,343		14,533,343	0	14,533,343	90.00
91.00	09100 EMERGENCY	2,638,634		2,638,634	325,594	2,964,228	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,548,266		2,548,266	0	2,548,266	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	725,418		725,418	0	725,418	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
116.00	11600 HOSPICE	1,419,802		1,419,802		1,419,802	116.00
200.00	Subtotal (see instructions)	64,582,154	0	64,582,154	534,840	65,116,994	200.00
201.00	Less Observation Beds	2,548,266		2,548,266		2,548,266	201.00
202.00	Total (see instructions)	62,033,888	0	62,033,888	534,840	62,568,728	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0143

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	6,564,798		6,564,798		30.00
31.00	03100	INTENSIVE CARE UNIT	1,820,207		1,820,207		31.00
43.00	04300	NURSERY	751,123		751,123		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	6,670,958	27,661,536	34,332,494	0.293286	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	928,738	128,983	1,057,721	0.801218	52.00
53.00	05300	ANESTHESIOLOGY	1,832,310	4,496,114	6,328,424	0.058373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,212,057	12,659,214	13,871,271	0.264879	54.00
54.01	05402	NUCLEAR MEDICINE	100,075	2,425,459	2,525,534	0.341237	54.01
57.00	05700	CT SCAN	1,623,053	14,327,305	15,950,358	0.058313	57.00
60.00	06000	LABORATORY	5,718,435	25,577,781	31,296,216	0.151502	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	227,813	208,108	435,921	0.663205	63.00
65.00	06500	RESPIRATORY THERAPY	2,321,479	924,839	3,246,318	0.257169	65.00
66.00	06600	PHYSICAL THERAPY	767,113	7,986,275	8,753,388	0.276035	66.00
67.00	06700	OCCUPATIONAL THERAPY	112,745	822,108	934,853	0.254520	67.00
68.00	06800	SPEECH PATHOLOGY	34,438	349,140	383,578	0.327746	68.00
69.00	06900	ELECTROCARDIOLOGY	1,550,652	3,117,325	4,667,977	0.091694	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,854	1,362,625	1,365,479	0.154440	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,143,243	3,899,398	10,042,641	0.064620	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,470,413	466,975	3,937,388	0.635498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,710,314	4,306,536	7,016,850	0.464438	73.00
76.00	03020	SONOGRAPHY	758,385	5,624,373	6,382,758	0.131642	76.00
76.01	03040	AUDIOLOGY	0	465,737	465,737	0.623075	76.01
76.02	03160	CARDIAC REHAB	7,662	949,616	957,278	0.331861	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
90.00	09000	CLINIC	46,000	6,769,431	6,815,431	2.132417	90.00
91.00	09100	EMERGENCY	1,240,382	7,753,656	8,994,038	0.293376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	921,665	3,555,619	4,477,284	0.569154	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	616,800	616,800	1.176099	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	3,145,157	3,145,157		116.00
200.00		Subtotal (see instructions)	47,536,912	139,600,110	187,137,022		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	47,536,912	139,600,110	187,137,022		202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet C Part I Date/Time Prepared: 4/24/2017 9:56 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.293286		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.801218		52.00
53.00	05300 ANESTHESIOLOGY	0.080633		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.264879		54.00
54.01	05402 NUCLEAR MEDICINE	0.341237		54.01
57.00	05700 CT SCAN	0.058313		57.00
60.00	06000 LABORATORY	0.151502		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.663205		63.00
65.00	06500 RESPIRATORY THERAPY	0.257169		65.00
66.00	06600 PHYSICAL THERAPY	0.276035		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.254520		67.00
68.00	06800 SPEECH PATHOLOGY	0.327746		68.00
69.00	06900 ELECTROCARDIOLOGY	0.091694		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.154440		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064620		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.635498		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.464438		73.00
76.00	03020 SONOGRAPHY	0.131642		76.00
76.01	03040 AUDIOLOGY	0.623075		76.01
76.02	03160 CARDIAC REHAB	0.331861		76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	2.132417		90.00
91.00	09100 EMERGENCY	0.329577		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.569154		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	1.176099		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 14-0143

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

Worksheet C  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	10,069,247	1,175,297	8,893,950	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	847,465	52,029	795,436	0	0 52.00
53.00	05300	ANESTHESIOLOGY	369,406	57,461	311,945	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,674,205	751,030	2,923,175	0	0 54.00
54.01	05402	NUCLEAR MEDICINE	861,805	142,357	719,448	0	0 54.01
57.00	05700	CT SCAN	930,117	196,234	733,883	0	0 57.00
60.00	06000	LABORATORY	4,741,453	254,587	4,486,866	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	289,105	11,989	277,116	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	834,853	68,751	766,102	0	0 65.00
66.00	06600	PHYSICAL THERAPY	2,416,242	207,580	2,208,662	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	237,939	8,568	229,371	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	125,716	6,092	119,624	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	428,025	32,627	395,398	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	210,885	20,876	190,009	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	648,959	112,883	536,076	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,502,204	82,980	2,419,224	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,258,893	172,827	3,086,066	0	0 73.00
76.00	03020	SONOGRAPHY	840,240	77,784	762,456	0	0 76.00
76.01	03040	AUDIOLOGY	290,189	9,697	280,492	0	0 76.01
76.02	03160	CARDIAC REHAB	317,683	32,836	284,847	0	0 76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	14,533,343	806,618	13,726,725	0	0 90.00
91.00	09100	EMERGENCY	2,638,634	271,606	2,367,028	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,548,266	264,795	2,283,471	0	0 92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	725,418	23,838	701,580	0	0 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,419,802	95,369	1,324,433	0	0 116.00
200.00		Subtotal (sum of lines 50 thru 199)	55,760,094	4,936,711	50,823,383	0	0 200.00
201.00		Less Observation Beds	2,548,266	264,795	2,283,471	0	0 201.00
202.00		Total (line 200 minus line 201)	53,211,828	4,671,916	48,539,912	0	0 202.00

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

Provider CCN: 14-0143

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

Worksheet C  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
Title XIX						
		Hospital		PPS		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,069,247	34,332,494	0.293286	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	847,465	1,057,721	0.801218	52.00
53.00	05300	ANESTHESIOLOGY	369,406	6,328,424	0.058373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,674,205	13,871,271	0.264879	54.00
54.01	05402	NUCLEAR MEDICINE	861,805	2,525,534	0.341237	54.01
57.00	05700	CT SCAN	930,117	15,950,358	0.058313	57.00
60.00	06000	LABORATORY	4,741,453	31,296,216	0.151502	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	289,105	435,921	0.663205	63.00
65.00	06500	RESPIRATORY THERAPY	834,853	3,246,318	0.257169	65.00
66.00	06600	PHYSICAL THERAPY	2,416,242	8,753,388	0.276035	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,939	934,853	0.254520	67.00
68.00	06800	SPEECH PATHOLOGY	125,716	383,578	0.327746	68.00
69.00	06900	ELECTROCARDIOLOGY	428,025	4,667,977	0.091694	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	210,885	1,365,479	0.154440	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	648,959	10,042,641	0.064620	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,502,204	3,937,388	0.635498	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,258,893	7,016,850	0.464438	73.00
76.00	03020	SONOGRAPHY	840,240	6,382,758	0.131642	76.00
76.01	03040	AUDIOLOGY	290,189	465,737	0.623075	76.01
76.02	03160	CARDIAC REHAB	317,683	957,278	0.331861	76.02
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	88.00
90.00	09000	CLINIC	14,533,343	6,815,431	2.132417	90.00
91.00	09100	EMERGENCY	2,638,634	8,994,038	0.293376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,548,266	4,477,284	0.569154	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	725,418	616,800	1.176099	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	1,419,802	3,145,157	0.451425	116.00
200.00		Subtotal (sum of lines 50 thru 199)	55,760,094	178,000,894		200.00
201.00		Less Observation Beds	2,548,266	0		201.00
202.00		Total (line 200 minus line 201)	53,211,828	178,000,894		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet D Part I Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	725,843	2,170	723,673	7,655	94.54	30.00
31.00	INTENSIVE CARE UNIT	148,840		148,840	832	178.89	31.00
43.00	NURSERY	76,624		76,624	718	106.72	43.00
200.00	Total (Lines 30-199)	951,307		949,137	9,205		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,817	266,319				
31.00	INTENSIVE CARE UNIT	520	93,023				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	3,337	359,342				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part II Date/Time Prepared: 4/24/2017 9:56 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,175,297	34,332,494	0.034233	3,226,228	110,443	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,029	1,057,721	0.049190	5,458	268	52.00
53.00	05300	ANESTHESIOLOGY	57,461	6,328,424	0.009080	875,569	7,950	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	751,030	13,871,271	0.054143	1,052,855	57,005	54.00
54.01	05402	NUCLEAR MEDICINE	142,357	2,525,534	0.056367	77,387	4,362	54.01
57.00	05700	CT SCAN	196,234	15,950,358	0.012303	1,226,962	15,095	57.00
60.00	06000	LABORATORY	254,587	31,296,216	0.008135	3,801,006	30,921	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,989	435,921	0.027503	169,486	4,661	63.00
65.00	06500	RESPIRATORY THERAPY	68,751	3,246,318	0.021178	569,011	12,051	65.00
66.00	06600	PHYSICAL THERAPY	207,580	8,753,388	0.023714	439,743	10,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,568	934,853	0.009165	64,157	588	67.00
68.00	06800	SPEECH PATHOLOGY	6,092	383,578	0.015882	24,394	387	68.00
69.00	06900	ELECTROCARDIOLOGY	32,627	4,667,977	0.006990	1,263,596	8,833	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,876	1,365,479	0.015288	2,602	40	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,883	10,042,641	0.011240	5,358,878	60,234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,980	3,937,388	0.021075	1,609,696	33,924	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,827	7,016,850	0.024630	1,583,227	38,995	73.00
76.00	03020	SONOGRAPHY	77,784	6,382,758	0.012187	508,683	6,199	76.00
76.01	03040	AUDIOLOGY	9,697	465,737	0.020821	0	0	76.01
76.02	03160	CARDIAC REHAB	32,836	957,278	0.034301	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	806,618	6,815,431	0.118352	43,543	5,153	90.00
91.00	09100	EMERGENCY	271,606	8,994,038	0.030198	1,032,464	31,178	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	264,795	4,477,284	0.059142	174,394	10,314	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	4,817,504	174,238,937		23,109,339	449,029	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet D Part III Date/Time Prepared: 4/24/2017 9:56 am			
Cost Center Description			Title XVIII			Hospital		PPS		
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)			
			1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0			31.00
43.00	04300	NURSERY	0	0	0	0	0			43.00
200.00		Total (lines 30-199)	0	0	0	0	0			200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)				
			6.00	7.00	8.00	9.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	7,655	0.00	2,817	0				30.00
31.00	03100	INTENSIVE CARE UNIT	832	0.00	520	0				31.00
43.00	04300	NURSERY	718	0.00	0	0				43.00
200.00		Total (lines 30-199)	9,205		3,337	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared: 4/24/2017 9:56 am
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared: 4/24/2017 9:56 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	34,332,494	0.000000	0.000000	3,226,228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,057,721	0.000000	0.000000	5,458	52.00
53.00	05300	ANESTHESIOLOGY	0	6,328,424	0.000000	0.000000	875,569	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,871,271	0.000000	0.000000	1,052,855	54.00
54.01	05402	NUCLEAR MEDICINE	0	2,525,534	0.000000	0.000000	77,387	54.01
57.00	05700	CT SCAN	0	15,950,358	0.000000	0.000000	1,226,962	57.00
60.00	06000	LABORATORY	0	31,296,216	0.000000	0.000000	3,801,006	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	435,921	0.000000	0.000000	169,486	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,246,318	0.000000	0.000000	569,011	65.00
66.00	06600	PHYSICAL THERAPY	0	8,753,388	0.000000	0.000000	439,743	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	934,853	0.000000	0.000000	64,157	67.00
68.00	06800	SPEECH PATHOLOGY	0	383,578	0.000000	0.000000	24,394	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,667,977	0.000000	0.000000	1,263,596	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,365,479	0.000000	0.000000	2,602	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,042,641	0.000000	0.000000	5,358,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,937,388	0.000000	0.000000	1,609,696	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,016,850	0.000000	0.000000	1,583,227	73.00
76.00	03020	SONOGRAPHY	0	6,382,758	0.000000	0.000000	508,683	76.00
76.01	03040	AUDIOLOGY	0	465,737	0.000000	0.000000	0	76.01
76.02	03160	CARDIAC REHAB	0	957,278	0.000000	0.000000	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	6,815,431	0.000000	0.000000	43,543	90.00
91.00	09100	EMERGENCY	0	8,994,038	0.000000	0.000000	1,032,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,477,284	0.000000	0.000000	174,394	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	174,238,937			23,109,339	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared: 4/24/2017 9:56 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		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	8,376,187	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	480	0		52.00
53.00	05300 ANESTHESIOLOGY	0	1,492,961	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,961,136	0		54.00
54.01	05402 NUCLEAR MEDICINE	0	1,216,087	0		54.01
57.00	05700 CT SCAN	0	5,002,879	0		57.00
60.00	06000 LABORATORY	0	3,856,959	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	96,391	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	507,451	0		65.00
66.00	06600 PHYSICAL THERAPY	0	19,964	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,272	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	915	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,351,551	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	106,096	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,066,950	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	216,559	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,272,600	0		73.00
76.00	03020 SONOGRAPHY	0	1,398,615	0		76.00
76.01	03040 AUDIOLOGY	0	70,910	0		76.01
76.02	03160 CARDIAC REHAB	0	77,164	0		76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000 CLINIC	0	1,324,442	0		90.00
91.00	09100 EMERGENCY	0	2,290,828	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	887,685	0		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	37,596,082	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part V Date/Time Prepared: 4/24/2017 9:56 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.293286	8,376,187	0	0	2,456,618	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.801218	480	0	0	385	52.00
53.00	05300 ANESTHESIOLOGY	0.058373	1,492,961	0	0	87,149	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.264879	4,961,136	0	0	1,314,101	54.00
54.01	05402 NUCLEAR MEDICINE	0.341237	1,216,087	0	0	414,974	54.01
57.00	05700 CT SCAN	0.058313	5,002,879	0	0	291,733	57.00
60.00	06000 LABORATORY	0.151502	3,856,959	982	0	584,337	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.663205	96,391	0	0	63,927	63.00
65.00	06500 RESPIRATORY THERAPY	0.257169	507,451	0	0	130,501	65.00
66.00	06600 PHYSICAL THERAPY	0.276035	19,964	0	0	5,511	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.254520	1,272	0	0	324	67.00
68.00	06800 SPEECH PATHOLOGY	0.327746	915	0	0	300	68.00
69.00	06900 ELECTROCARDIOLOGY	0.091694	1,351,551	0	0	123,929	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.154440	106,096	0	0	16,385	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064620	2,066,950	0	0	133,566	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.635498	216,559	0	0	137,623	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.464438	2,272,600	1,916	116,940	1,055,482	73.00
76.00	03020 SONOGRAPHY	0.131642	1,398,615	0	0	184,116	76.00
76.01	03040 AUDIOLOGY	0.623075	70,910	0	0	44,182	76.01
76.02	03160 CARDIAC REHAB	0.331861	77,164	0	0	25,608	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000 CLINIC	2.132417	1,324,442	273	0	2,824,263	90.00
91.00	09100 EMERGENCY	0.293376	2,290,828	0	0	672,074	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.569154	887,685	0	0	505,229	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	1.176099		0			95.00
200.00	Subtotal (see instructions)		37,596,082	3,171	116,940	11,072,317	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		37,596,082	3,171	116,940	11,072,317	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part V Date/Time Prepared: 4/24/2017 9:56 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05402 NUCLEAR MEDICINE	0	0	54.01
57.00	05700 CT SCAN	0	0	57.00
60.00	06000 LABORATORY	149	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	890	54,311	73.00
76.00	03020 SONOGRAPHY	0	0	76.00
76.01	03040 AUDIOLOGY	0	0	76.01
76.02	03160 CARDIAC REHAB	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	582	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	1,621	54,311	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,621	54,311	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet D Part I Date/Time Prepared: 4/24/2017 9:56 am		
Cost Center Description		Title XIX		Hospital		PPS		
		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	725,843	2,170	723,673	7,655	94.54	30.00	
31.00	INTENSIVE CARE UNIT	148,840		148,840	832	178.89	31.00	
43.00	NURSERY	76,624		76,624	718	106.72	43.00	
200.00	Total (Lines 30-199)	951,307		949,137	9,205		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	496	46,892					30.00
31.00	INTENSIVE CARE UNIT	54	9,660					31.00
43.00	NURSERY	383	40,874					43.00
200.00	Total (Lines 30-199)	933	97,426					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part II Date/Time Prepared: 4/24/2017 9:56 am
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Cost Center Description		Title XIX			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,175,297	34,332,494	0.034233	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,029	1,057,721	0.049190	0	0	52.00
53.00	05300	ANESTHESIOLOGY	57,461	6,328,424	0.009080	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	751,030	13,871,271	0.054143	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	142,357	2,525,534	0.056367	0	0	54.01
57.00	05700	CT SCAN	196,234	15,950,358	0.012303	0	0	57.00
60.00	06000	LABORATORY	254,587	31,296,216	0.008135	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,989	435,921	0.027503	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	68,751	3,246,318	0.021178	0	0	65.00
66.00	06600	PHYSICAL THERAPY	207,580	8,753,388	0.023714	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,568	934,853	0.009165	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,092	383,578	0.015882	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,627	4,667,977	0.006990	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,876	1,365,479	0.015288	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,883	10,042,641	0.011240	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	82,980	3,937,388	0.021075	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,827	7,016,850	0.024630	0	0	73.00
76.00	03020	SONOGRAPHY	77,784	6,382,758	0.012187	0	0	76.00
76.01	03040	AUDIOLOGY	9,697	465,737	0.020821	0	0	76.01
76.02	03160	CARDIAC REHAB	32,836	957,278	0.034301	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	806,618	6,815,431	0.118352	0	0	90.00
91.00	09100	EMERGENCY	271,606	8,994,038	0.030198	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	264,795	4,477,284	0.059142	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	4,817,504	174,238,937		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet D Part III Date/Time Prepared: 4/24/2017 9:56 am			
Cost Center Description			Title XIX			Hospital		PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)			
			1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0			31.00
43.00	04300	NURSERY	0	0	0	0	0			43.00
200.00		Total (lines 30-199)	0	0	0	0	0			200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)				
			6.00	7.00	8.00	9.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	7,655	0.00	496	0				30.00
31.00	03100	INTENSIVE CARE UNIT	832	0.00	54	0				31.00
43.00	04300	NURSERY	718	0.00	383	0				43.00
200.00		Total (lines 30-199)	9,205		933	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143

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

Worksheet D  
Part IV  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared: 4/24/2017 9:56 am
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Cost Center Description		Title XIX			Hospital		PPS	
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	34,332,494	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,057,721	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	6,328,424	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,871,271	0.000000	0.000000	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	2,525,534	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	15,950,358	0.000000	0.000000	0	57.00
60.00	06000	LABORATORY	0	31,296,216	0.000000	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	435,921	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,246,318	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,753,388	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	934,853	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	383,578	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,667,977	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,365,479	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,042,641	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,937,388	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,016,850	0.000000	0.000000	0	73.00
76.00	03020	SONOGRAPHY	0	6,382,758	0.000000	0.000000	0	76.00
76.01	03040	AUDIOLOGY	0	465,737	0.000000	0.000000	0	76.01
76.02	03160	CARDIAC REHAB	0	957,278	0.000000	0.000000	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	6,815,431	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	8,994,038	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,477,284	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0			0	95.00
200.00		Total (lines 50-199)	0	174,238,937			0	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared: 4/24/2017 9:56 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XIX Hospital PPS						
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05402 NUCLEAR MEDICINE	0	0	0		54.01
57.00	05700 CT SCAN	0	0	0		57.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 SONOGRAPHY	0	0	0		76.00
76.01	03040 AUDIOLOGY	0	0	0		76.01
76.02	03160 CARDIAC REHAB	0	0	0		76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 4/24/2017 9:56 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,745	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,655	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		2,029	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,825	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		22	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)		68	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,817	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)		20	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)		60	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		227.71	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		233.41	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,985,192	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)		5,010	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)		15,872	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)		20,882	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,964,310	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		8,592,643	28.00
29.00	Private room charges (excluding swing-bed charges)		3,403,255	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,189,388	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.810497	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,677.31	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,836.95	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,964,310	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		909.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,562,822	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)		2,562,822	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,575,825	832	1,894.02	520	984,890		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)					5,198,495		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,746,207		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)					359,342		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					449,029		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					808,371		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,937,836		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)					4,554		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					14,005		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					18,559		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					2,801		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					909.77		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,548,266		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet D-1 Date/Time Prepared: 4/24/2017 9:56 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	725,843	6,985,192	0.103912	2,548,266	264,795	90.00
91.00	Nursing School cost	0	6,985,192	0.000000	2,548,266	0	91.00
92.00	Allied health cost	0	6,985,192	0.000000	2,548,266	0	92.00
93.00	All other Medical Education	0	6,985,192	0.000000	2,548,266	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 4/24/2017 9:56 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,745	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,655	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)		4,854	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		22	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)		68	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)		496	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)		718	15.00
16.00	Nursery days (title V or XIX only)		383	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		227.71	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		233.41	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,985,192	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)		5,010	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)		15,872	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)		20,882	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,964,310	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,964,310	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		909.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		451,246	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)		451,246	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	329,418	718	458.80	383	175,720		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,575,825	832	1,894.02	54	102,277		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						729,243	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)						97,426	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						97,426	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						631,817	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						2,801	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						909.77	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						2,548,266	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet D-1 Date/Time Prepared: 4/24/2017 9:56 am	
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	725,843	6,985,192	0.103912	2,548,266	264,795	90.00
91.00	Nursing School cost	0	6,985,192	0.000000	2,548,266	0	91.00
92.00	Allied health cost	0	6,985,192	0.000000	2,548,266	0	92.00
93.00	All other Medical Education	0	6,985,192	0.000000	2,548,266	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet D-3 Date/Time Prepared: 4/24/2017 9:56 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,607,000		30.00
31.00	03100 INTENSIVE CARE UNIT		1,169,375		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.293286	3,226,228	946,208	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.801218	5,458	4,373	52.00
53.00	05300 ANESTHESIOLOGY	0.080633	875,569	70,600	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.264879	1,052,855	278,879	54.00
54.01	05402 NUCLEAR MEDICINE	0.341237	77,387	26,407	54.01
57.00	05700 CT SCAN	0.058313	1,226,962	71,548	57.00
60.00	06000 LABORATORY	0.151502	3,801,006	575,860	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.663205	169,486	112,404	63.00
65.00	06500 RESPIRATORY THERAPY	0.257169	569,011	146,332	65.00
66.00	06600 PHYSICAL THERAPY	0.276035	439,743	121,384	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.254520	64,157	16,329	67.00
68.00	06800 SPEECH PATHOLOGY	0.327746	24,394	7,995	68.00
69.00	06900 ELECTROCARDIOLOGY	0.091694	1,263,596	115,864	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.154440	2,602	402	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064620	5,358,878	346,291	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.635498	1,609,696	1,022,959	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.464438	1,583,227	735,311	73.00
76.00	03020 SONOGRAPHY	0.131642	508,683	66,964	76.00
76.01	03040 AUDIOLOGY	0.623075	0	0	76.01
76.02	03160 CARDIAC REHAB	0.331861	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	2.132417	43,543	92,852	90.00
91.00	09100 EMERGENCY	0.329577	1,032,464	340,276	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.569154	174,394	99,257	92.00
93.00	04040 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		23,109,339	5,198,495	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)		23,109,339		202.00



INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0143 Component CCN: 14-U143	Period: From 10/01/2015 To 09/30/2016	Worksheet D-3 Date/Time Prepared: 4/24/2017 9:56 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.293286	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.801218	0	52.00
53.00	05300	ANESTHESIOLOGY	0.058373	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.264879	5,328	1,411
54.01	05402	NUCLEAR MEDICINE	0.341237	0	54.01
57.00	05700	CT SCAN	0.058313	0	57.00
60.00	06000	LABORATORY	0.151502	24,321	3,685
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.663205	1,464	971
65.00	06500	RESPIRATORY THERAPY	0.257169	7,003	1,801
66.00	06600	PHYSICAL THERAPY	0.276035	13,325	3,678
67.00	06700	OCCUPATIONAL THERAPY	0.254520	1,206	307
68.00	06800	SPEECH PATHOLOGY	0.327746	738	242
69.00	06900	ELECTROCARDIOLOGY	0.091694	1,759	161
70.00	07000	ELECTROENCEPHALOGRAPHY	0.154440	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064620	72,669	4,696
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.635498	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.464438	19,775	9,184
76.00	03020	SONOGRAPHY	0.131642	0	76.00
76.01	03040	AUDIOLOGY	0.623075	0	76.01
76.02	03160	CARDIAC REHAB	0.331861	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	2.132417	1,820	3,881
91.00	09100	EMERGENCY	0.293376	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.569154	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		149,408	30,017
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	
202.00		Net Charges (line 200 minus line 201)		149,408	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 4/24/2017 9:56 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6,282,623	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)		36,585	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		55.10	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.48	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.26	31.00
32.00	Sum of lines 30 and 31		16.74	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.63	33.00
34.00	Disproportionate share adjustment (see instructions)		57,015	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 4/24/2017 9:56 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000029300	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	187,700	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	187,700	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		187,700		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
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 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		6,563,923		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		7,773,056		48.00
				<b>Amount</b>	
				<b>1.00</b>	
49.00	Total payment for inpatient operating costs (see instructions)			7,470,773	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			503,265	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
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 instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			7,974,038	59.00
60.00	Primary payer payments			3,612	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			7,970,426	61.00
62.00	Deductibles billed to program beneficiaries			824,956	62.00
63.00	Coinurance billed to program beneficiaries			971	63.00
64.00	Allowable bad debts (see instructions)			15,509	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			10,081	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			12,953	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			7,154,580	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS			0	70.00
70.50	RURAL DEMONSTRATION PROJECT			0	70.50
70.88	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)			-509	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-1,179	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-3,504	70.93
70.94	HRR adjustment amount (see instructions)			-8,121	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 4/24/2017 9:56 am	
		Title XVIII	Hospital	PPS	
		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	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	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			7,141,267	71.00
71.01	Sequestration adjustment (see instructions)			142,825	71.01
72.00	Interim payments			7,007,985	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)			-9,543	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			14,731	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
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	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			906,850	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)			0.9994391850	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			-509	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)			0.9987	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			-1,179	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0143

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
4/24/2017 9:56 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,282,623	0	0	6,247,288	6,247,288	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	36,585	0	0	36,585	36,585	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0363	0.0363	0.0363	0.0363	0.0363	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	57,015	0	0	57,015	57,015	11.00
11.01	Uncompensated care payments	36.00	187,700	0	0	187,700	187,700	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,563,923	0	0	6,563,923	6,563,923	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,773,056	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,470,773	0	0	7,470,773	7,470,773	15.00
16.00	Payment for inpatient program capital	50.00	503,265	0	0	503,265	503,265	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0143

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
4/24/2017 9:56 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	0	7,974,038	7,974,038	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	496,688	0	0	496,688	496,688	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,577	0	0	6,577	6,577	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	503,265	0	0	503,265	503,265	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.070000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				558,183	558,183	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0143		Period: From 10/01/2015 To 09/30/2016		Worksheet E Part A Exhibit 5 Date/Time Prepared: 4/24/2017 9:56 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,282,623		6,247,288	6,247,288	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	36,585	0	36,585	36,585	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0363	0.0363	0.0363		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	57,015	0	57,015	57,015	11.00
11.01	Uncompensated care payments	36.00	187,700	0	187,700	187,700	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	6,563,923	0	6,563,923	6,563,923	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,773,056	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,470,773	0	7,470,773	7,470,773	15.00
16.00	Payment for inpatient program capital	50.00	503,265	0	503,265	503,265	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	<b>SUBTOTAL</b>			0	7,974,038	7,974,038	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0143

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

Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
4/24/2017 9:56 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	496,688	0	496,688	496,688	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,577	0	6,577	6,577	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	503,265	0	503,265	503,265	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-3,504	0	-3,504	-3,504	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-509	0	-509	-509	30.01
31.00	HRR adjustment (see instructions)	70.94	-8,121	0	-8,121	-8,121	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-1,179	0	-1,179	-1,179	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 4/24/2017 9:56 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		55,932	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,072,317	2.00
3.00	PPS payments		8,089,751	3.00
4.00	Outlier payment (see instructions)		113,920	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.799	5.00
6.00	Line 2 times line 5		8,846,781	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		92.73	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)		55,932	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		120,111	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)		120,111	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		120,111	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		64,179	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)		55,932	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		8,203,671	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		55	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,787,513	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		6,472,035	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		6,472,035	30.00
31.00	Primary payer payments		2,531	31.00
32.00	Subtotal (line 30 minus line 31)		6,469,504	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		452,005	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		293,803	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		340,088	36.00
37.00	Subtotal (see instructions)		6,763,307	37.00
38.00	MSP-LCC reconciliation amount from PS&R		386	38.00
39.00	OTHER PSR ADJUSTMENTS		51,739	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		6,814,660	40.00
40.01	Sequestration adjustment (see instructions)		136,293	40.01
41.00	Interim payments		6,508,829	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		169,538	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0143

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 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		7,493,969		6,508,829	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	09/27/2016	485,984		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)		-485,984		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,007,985		6,508,829	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		169,538	6.01	
6.02	SETTLEMENT TO PROGRAM		9,543		0	6.02	
7.00	Total Medicare program liability (see instructions)		6,998,442		6,678,367	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: 14-0143  
Component CCN: 14-U143

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Title XVIII Swing Beds - SNF PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		24,804		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		24,804		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		24,804		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 4/24/2017 9:56 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1,747	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		3,337	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		617	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		5,686	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		187,137,022	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		2,763,260	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)		374,004	8.00
9.00	Sequestration adjustment amount (see instructions)		7,480	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		366,524	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
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)		366,524	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-0143  
Component CCN: 14-U143

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

Worksheet E-2  
Date/Time Prepared:  
4/24/2017 9:56 am

		Title XVIII		Swing Beds - SNF	
		PPS			
		Part A	Part B		
		1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	28,531	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	80	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	28,531	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	28,531	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	28,531	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,221	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	25,310	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50	
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	65	0	18.00	
19.00	Total (see instructions)	25,310	0	19.00	
19.01	Sequestration adjustment (see instructions)	506	0	19.01	
20.00	Interim payments	24,804	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00	

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

Provider CCN: 14-0143

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

Worksheet G

Date/Time Prepared:  
4/24/2017 9:56 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,682,754	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,500,429	0	0	0	4.00
5.00	Other receivable	390,355	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,413,000	0	0	0	6.00
7.00	Inventory	1,956,111	0	0	0	7.00
8.00	Prepaid expenses	624,129	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,740,778	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,762,328	0	0	0	12.00
13.00	Land improvements	2,749,678	0	0	0	13.00
14.00	Accumulated depreciation	-2,129,166	0	0	0	14.00
15.00	Buildings	66,656,364	0	0	0	15.00
16.00	Accumulated depreciation	-34,467,784	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	27,436,037	0	0	0	23.00
24.00	Accumulated depreciation	-21,121,963	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	2,780,389	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	44,665,883	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	26,288,263	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	1,818,755	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	28,107,018	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	91,513,679	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	7,813,249	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,679,931	0	0	0	38.00
39.00	Payroll taxes payable	233,232	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,163,627	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	175,112	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,065,151	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	21,859,295	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,422,501	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,281,796	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,346,947	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	55,166,732				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)	55,166,732	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	91,513,679	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0143

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

Worksheet G-1

Date/Time Prepared:  
4/24/2017 9:56 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		52,319,190		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,785,565			2.00
3.00	Total (sum of line 1 and line 2)		55,104,755		0	3.00
4.00	CONTRIBUTIONS	313,150		0		4.00
5.00	RESTRICTED CONTRIBUTIONS	2,451		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		315,601		0	10.00
11.00	Subtotal (line 3 plus line 10)		55,420,356		0	11.00
12.00	EQUITY TRANSFER	85,405		0		12.00
13.00	CHANGE IN FOUNDATION INTEREST	168,219		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		253,624		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		55,166,732		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	CONTRIBUTIONS		0			4.00
5.00	RESTRICTED CONTRIBUTIONS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	EQUITY TRANSFER		0			12.00
13.00	CHANGE IN FOUNDATION INTEREST		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0143

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	8,592,643		8,592,643	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,592,643		8,592,643	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,360,450		3,360,450	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,360,450		3,360,450	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,953,093		11,953,093	17.00
18.00	Ancillary services	38,009,183	136,002,535	174,011,718	18.00
19.00	Outpatient services	0	25,997,013	25,997,013	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	618,933	618,933	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	3,145,837	3,145,837	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	49,962,276	165,764,318	215,726,594	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		78,478,056		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)		78,478,056		43.00



STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet G-3 Date/Time Prepared: 4/24/2017 9:56 am
			1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		215,726,594	1.00
2.00	Less contractual allowances and discounts on patients' accounts		138,807,854	2.00
3.00	Net patient revenues (line 1 minus line 2)		76,918,740	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		78,478,056	4.00
5.00	Net income from service to patients (line 3 minus line 4)		-1,559,316	5.00
<b>OTHER INCOME</b>				
6.00	Contributions, donations, bequests, etc		0	6.00
7.00	Income from investments		0	7.00
8.00	Revenues from telephone and other miscellaneous communication services		0	8.00
9.00	Revenue from television and radio service		0	9.00
10.00	Purchase discounts		0	10.00
11.00	Rebates and refunds of expenses		0	11.00
12.00	Parking lot receipts		0	12.00
13.00	Revenue from laundry and linen service		0	13.00
14.00	Revenue from meals sold to employees and guests		206,563	14.00
15.00	Revenue from rental of living quarters		65,831	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		310,254	17.00
18.00	Revenue from sale of medical records and abstracts		2,065	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen		0	20.00
21.00	Rental of vending machines		0	21.00
22.00	Rental of hospital space		133,510	22.00
23.00	Governmental appropriations		0	23.00
24.00	LOSS ON DISPOSAL OF EQUIPMENT		0	24.00
24.01	EMR REVENUE		1,033,517	24.01
24.02	OTHER		0	24.02
24.03	OTHER REVENUE		164,198	24.03
24.04	PARATRANSIT		189,443	24.04
24.05	OUTSIDE REHABILITATION SERVICES		20,224	24.05
24.06	CONTRIBUTIONS SPENT FOR OPERATIONS		291,055	24.06
24.07	INVESTMENT INCOME		1,953,025	24.07
25.00	Total other income (sum of lines 6-24)		4,369,685	25.00
26.00	Total (line 5 plus line 25)		2,810,369	26.00
27.00	NET RENTAL LOSS		674	27.00
27.01	OTHER		0	27.01
27.02	CHANGE IN EQUITY GAINS AND LOSSES		24,130	27.02
27.03	MISCELLANEOUS		0	27.03
27.04			0	27.04
27.05			0	27.05
28.00	Total other expenses (sum of line 27 and subscripts)		24,804	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		2,785,565	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143

Period: From 10/01/2015

Worksheet 0

Hospice CCN: 14-1595

To 09/30/2016

Date/Time Prepared: 4/24/2017 9:56 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	44,732	44,732	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	12,070	12,070	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	30,743	30,743	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	13.00
14.00	PHARMACY*	0	5,545	5,545	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*					16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	12,000	12,000	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	27.00
28.00	REGISTERED NURSE**	380,121	0	380,121	0	28.00
29.00	LPN/LVN**	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	46,688	0	46,688	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	28,385	0	28,385	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	431,653	431,653	0	46.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	455,194	536,743	991,937	0	100.00

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS	Provider CCN: 14-0143 Hospice CCN: 14-1595	Period: From 10/01/2015 To 09/30/2016	Worksheet 0 Date/Time Prepared: 4/24/2017 9:56 am
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		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
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	44,732	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	12,070	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	30,743	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	5,545	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	17.00
<b>DIRECT PATIENT CARE SERVICE COST CENTERS</b>				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	12,000	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	380,121	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	46,688	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	28,385	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	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	431,653	46.00
<b>NONREIMBURSABLE COST CENTERS</b>				
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	0	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	0	991,937	100.00

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

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

Provider CCN: 14-0143

Period: From 10/01/2015

Worksheet 0-1

Hospice CCN: 14-1595

To 09/30/2016

Date/Time Prepared: 4/24/2017 9:56 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED					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	0	0	0	0	0 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	0	0	0	0	0 33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0 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 & HOME MAKER SERVICES	0	0	0	0	0 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0 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 *	0	0	0	0	0 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

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

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

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

Provider CCN: 14-0143

Period: From 10/01/2015

Worksheet 0-2

Hospice CCN: 14-1595

To 09/30/2016

Date/Time Prepared: 4/24/2017 9:56 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	0	11,813	11,813	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	374,212	0	374,212	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	45,962	0	45,962	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	27,944	0	27,944	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	424,943	424,943	0	46.00
100.00	TOTAL *	448,118	436,756	884,874	0	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)
		6.00	7.00
<b>DI RECT PATIENT CARE SERVICE COST CENTERS</b>			
25.00	INPATIENT CARE-CONTRACTED		
26.00	PHYSICIAN SERVICES	0	11,813
27.00	NURSE PRACTITIONER	0	0
28.00	REGISTERED NURSE	0	374,212
29.00	LPN/LVN	0	0
30.00	PHYSICAL THERAPY	0	0
31.00	OCCUPATIONAL THERAPY	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0
33.00	MEDICAL SOCIAL SERVICES	0	45,962
34.00	SPIRITUAL COUNSELING	0	0
35.00	DIETARY COUNSELING	0	0
36.00	COUNSELING - OTHER	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	27,944
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0
39.00	PATIENT TRANSPORTATION	0	0
40.00	IMAGING SERVICES	0	0
41.00	LABS & DIAGNOSTICS	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0
43.00	OUTPATIENT SERVICES	0	0
44.00	PALLIATIVE RADIATION THERAPY	0	0
45.00	PALLIATIVE CHEMOTHERAPY	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	424,943
100.00	TOTAL *	0	884,874

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPI CE COSTS FOR HOSPI CE INPATIENT  
RESPI TE CARE

Provider CCN: 14-0143

Period:

Worksheet 0-3

Hospice CCN: 14-1595

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

Date/Time Prepared:  
4/24/2017 9:56 am

		Hospice I				
		SALARIES	OTHER	RECLASSIFI -	SUBTOTAL	
		1.00	2.00	CATIONS	5.00	
		SUBTOTAL (col .				
		1 + col . 2)			3.00	
					4.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	33	33	0	33 26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0 27.00
28.00	REGISTERED NURSE	1,043	0	1,043	0	1,043 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	128	0	128	0	128 33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0 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	HOSPI CE AIDE & HOME MAKER SERVICES	78	0	78	0	78 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	1,184	1,184	0	1,184 46.00
100.00	TOTAL *	1,249	1,217	2,466	0	2,466 100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col . 5		
		6.00	± col . 6)		
		7.00			
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	33		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	1,043		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	128		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPI CE AIDE & HOME MAKER SERVICES	0	78		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	1,184		46.00
100.00	TOTAL *	0	2,466		100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE	Provider CCN: 14-0143 Hospice CCN: 14-1595	Period: From 10/01/2015 To 09/30/2016	Worksheet 0-4 Date/Time Prepared: 4/24/2017 9:56 am
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		SALARIES	OTHER	SUBTOTAL (col . 1 + col . 2)	Hospice I 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	154	154	0	154	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	4,866	0	4,866	0	4,866	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	598	0	598	0	598	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	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 & HOME MAKER SERVICES	363	0	363	0	363	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	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	5,526	5,526	0	5,526	46.00
100.00	TOTAL *	5,827	5,680	11,507	0	11,507	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, 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	0	0	25.00
26.00	PHYSICIAN SERVICES	0	154	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	4,866	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	598	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	363	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	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	5,526	46.00
100.00	TOTAL *	0	11,507	100.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

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

Provider CCN: 14-0143

Period: From 10/01/2015

Worksheet 0-5

Hospice CCN: 14-1595

To 09/30/2016

Date/Time Prepared: 4/24/2017 9:56 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	0	8,002	8,002	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	106,301	106,301	3.00
4.00	ADMINISTRATIVE & GENERAL	44,732	255,018	299,750	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	17,016	17,016	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	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	12,070	0	12,070	10.00
11.00	MEDICAL RECORDS	0	41,528	41,528	11.00
12.00	STAFF TRANSPORTATION	30,743	0	30,743	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	5,545	0	5,545	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	0	17.00
<b>LEVEL OF CARE</b>					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	884,874	0	884,874	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	2,466	0	2,466	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	11,507	0	11,507	53.00
<b>NONREIMBURSABLE COST CENTERS</b>					
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	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	991,937	427,865	1,419,802	100.00



COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period: From 10/01/2015

Worksheet 0-6

Hospice CCN: 14-1595

To 09/30/2016

Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Descriptions	Hospice I				SUBTOTAL	
	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT		
	0	1.00	2.00	3.00	3A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	8,002	8,002			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	106,301	0	0	106,301	3.00
4.00	ADMINISTRATIVE & GENERAL	299,750	8,002	0	0	4.00
5.00	PLANT OPERATION & MAINTENANCE	17,016	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	12,070	0	0	0	10.00
11.00	MEDICAL RECORDS	41,528	0	0	0	11.00
12.00	STAFF TRANSPORTATION	30,743	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	13.00
14.00	PHARMACY	5,545	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	50.00
51.00	HOSPICE ROUTINE HOME CARE	884,874			104,648	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	2,466	0	0	292	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	11,507	0	0	1,361	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	1,419,802	8,002	0	106,301	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period: From 10/01/2015

Worksheet 0-6

Hospice CCN: 14-1595

To 09/30/2016

Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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	307,752					4.00
5.00 PLANT OPERATION & MAINTENANCE	4,709	21,725				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	0	0		0		9.00
10.00 ROUTINE MEDICAL SUPPLIES	3,340	0		0		10.00
11.00 MEDICAL RECORDS	11,493	0		0		11.00
12.00 STAFF TRANSPORTATION	8,508	0		0		12.00
13.00 VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00 PHARMACY	1,535	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		0		17.00
<b>LEVEL OF CARE</b>						
50.00 HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00 HOSPICE ROUTINE HOME CARE	273,843					51.00
52.00 HOSPICE INPATIENT RESPIRE CARE	763	3,836	0	0	0	52.00
53.00 HOSPICE GENERAL INPATIENT CARE	3,561	17,889	0	0	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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	0	0	0	0	0	99.00
100.00 TOTAL	307,752	21,725	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

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

Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Descriptions	Hospice I					
	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00	NURSING ADMINISTRATION	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	15,410			10.00
11.00	MEDICAL RECORDS	0		53,021		11.00
12.00	STAFF TRANSPORTATION	0			39,251	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	13.00
14.00	PHARMACY	0			0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0			0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			0	17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	15,171	52,197	39,251	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	42	145	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	197	679	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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			0	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					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	0	15,410	53,021	39,251	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143

Period: From 10/01/2015

Worksheet 0-6

Hospice CCN: 14-1595

To 09/30/2016

Part I  
Date/Time Prepared:  
4/24/2017 9:56 am

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	7,080					14.00
15.00	0	0				15.00
16.00	0		0			16.00
17.00				0		17.00
<b>LEVEL OF CARE</b>						
50.00	0	0	0		0	50.00
51.00	6,970	0	0		1,376,954	51.00
52.00	19	0	0	0	7,563	52.00
53.00	91	0	0	0	35,285	53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00					0	70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	7,080	0	0	0	1,419,802	100.00

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

Provider CCN: 14-0143

Hospice CCN: 14-1595

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

Worksheet 0-6  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIX	974					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		974				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	455,194			3.00
4.00	ADMINISTRATIVE & GENERAL	974	974	0	-307,752	1,112,050	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	17,016	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	12,070	10.00
11.00	MEDICAL RECORDS	0	0	0	0	41,528	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	30,743	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	5,545	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			448,118	0	989,522	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	0	1,249	0	2,758	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	5,827	0	12,868	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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	0	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
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	8,002	0	106,301		307,752	100.00
101.00	UNIT COST MULTIPLIER	8.215606	0.000000	0.233529		0.276743	101.00

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

Provider CCN: 14-0143

Period:

Worksheet 0-6

Hospice CCN: 14-1595

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

Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Descriptions		Hospice I					
		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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	974					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		974			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		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	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		0	17.00
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	172	0	172	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	802	0	802	0	0	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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. 0-6, Part I)	21,725	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	22.304928	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 14-0143

Hospice CCN: 14-1595

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

Worksheet 0-6  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Descriptions		Hospice I					
		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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	5,468					10.00
11.00	MEDICAL RECORDS		5,468				11.00
12.00	STAFF TRANSPORTATION			100			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	5,468	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
<b>LEVEL OF CARE</b>							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	5,383	5,383	100	0	5,383	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	15	15	0	0	15	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	70	70	0	0	70	53.00
<b>NONREIMBURSABLE COST CENTERS</b>							
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			0	0	0	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. 0-6, Part I)	15,410	53,021	39,251	0	7,080	100.00
101.00	UNIT COST MULTIPLIER	2.818215	9.696598	392.510000	0.000000	1.294806	101.00

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

Provider CCN: 14-0143

Hospice CCN: 14-1595

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

Worksheet 0-6  
Part II  
Date/Time Prepared:  
4/24/2017 9:56 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>						
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	5,468				15.00
16.00	OTHER GENERAL SERVICE (DELETED)		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
<b>LEVEL OF CARE</b>						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	5,383	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	15	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	70	0	0		53.00
<b>NONREIMBURSABLE COST CENTERS</b>						
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		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00



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

Provider CCN: 14-0143

Period: From 10/01/2015

Worksheet 0-7

Hospice CCN: 14-1595

To 09/30/2016

Date/Time Prepared: 4/24/2017 9:56 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS		0	1.00	2.00	3.00	4.00	
1.00	PHYSICAL THERAPY	66.00	0.276035	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.254520	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.327746	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.464438	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.151502	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.064620	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.000000	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	SONOGRAPHY	76.00	0.131642	0	0	0	10.00
10.01	AUDIOLOGY	76.01	0.623075	0	0	0	10.01
10.02	CARDIAC REHAB	76.02	0.331861	0	0	0	10.02
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)		Shared Service Costs by LOC			
		HGIP	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
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	SONOGRAPHY	0	0	0	0	0	10.00
10.01	AUDIOLOGY	0	0	0	0	0	10.01
10.02	CARDIAC REHAB	0	0	0	0	0	10.02
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0143

Period:

Worksheet 0-8

Hospice CCN: 14-1595

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

Date/Time Prepared:  
4/24/2017 9:56 am

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
<b>HOSPICE CONTINUOUS HOME CARE</b>				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0	0
5.00	Program cost (line 3 times line 4)	0	0	0
<b>HOSPICE ROUTINE HOME CARE</b>				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,376,954
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			5,383
8.00	Total average cost per diem (line 6 divided by line 7)			255.80
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	5,383	0	5,383
10.00	Program cost (line 8 times line 9)	1,376,971	0	1,376,971
<b>HOSPICE INPATIENT RESPITE CARE</b>				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			7,563
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			15
13.00	Total average cost per diem (line 11 divided by line 12)			504.20
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	15	0	15
15.00	Program cost (line 13 times line 14)	7,563	0	7,563
<b>HOSPICE GENERAL INPATIENT CARE</b>				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			35,285
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			70
18.00	Total average cost per diem (line 16 divided by line 17)			504.07
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	70	0	70
20.00	Program cost (line 18 times line 19)	35,285	0	35,285
<b>TOTAL HOSPICE CARE</b>				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,419,802
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			5,468
23.00	Average cost per diem (line 21 divided by line 22)			259.66

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0143	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 4/24/2017 9:56 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		496,688	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,577	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)		15.91	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		503,265	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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