This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150045	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/25/2015 12:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2015 Time: 12:39 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DEKALB MEMORIAL HOSPITAL (150045) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-9,650	71,185	-35,556	-369,002	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
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00	Total	0	-9,650	71,184	-35,556	-369,002	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2015 12:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1316 EAST 7TH STREET	PO Box:			1.00
2.00	City: AUBURN	State: IN	Zip Code: 46706-	County: DEKALB	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	DEKALB MEMORIAL HOSPITAL	150045	99915	1	07/01/1966	N	P	O	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									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	DEKALB HOME HEALTH AGENCY	157157	99915		07/09/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	DEKALB HOSPICE	151559	99915		11/06/1996				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
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	09/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	461	384	0	25	775	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2015 12:25 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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 in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2015 12:25 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2015 12:25 pm

		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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

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		V	XIX	
		1.00	2.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: 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 would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If 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 hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	281,393	22,000	3,364	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

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		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		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:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
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, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2015 12:25 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/01/2014	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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been 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	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	12/10/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2015 12:25 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MICHAEL	ALESSANDRINI		41.00
42.00	Enter the employer/company name of the cost report preparer.		BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		317-713-7959	MALESSANDRINI@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2015 12:25 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	12/10/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR MANAGER		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: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2015 12:25 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	41	14,965	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)		41	14,965	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		47	17,155	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		47				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: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2015 12:25 pm

	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)	1,535	450	4,519			1.00
2.00	HMO and other (see instructions)	867	1,110				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,535	450	4,519			7.00
8.00	INTENSIVE CARE UNIT	474	0	1,286			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	996			13.00
14.00	Total (see instructions)	2,009	450	6,801	0.00	435.36	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	4,835	0	9,106	0.00	2.50	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	3,312	3,504	0.00	18.38	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	456.24	27.00
28.00	Observation Bed Days		124	715			28.00
29.00	Ambulance Trips	1,115					29.00
30.00	Employee discount days (see instruction)			120			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	85	155			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: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2015 12:25 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	579	102	2,050	1.00
2.00	HMO and other (see instructions)			242	283		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						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	579	102	2,050	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part II Date/Time Prepared: 2/25/2015 12:25 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	24,854,436	0	24,854,436	960,822.00	25.87	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		146,331	0	146,331	1,117.00	131.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		8,401,070	-149,905	8,251,165	280,455.00	29.42	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		913,215	0	913,215	11,673.00	78.23	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		207,217	0	207,217	1,929.00	107.42	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,962,223	0	4,962,223			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,135,387	0	2,135,387			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		15,245	0	15,245			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	194,292	-3,652	190,640	5,380.00	35.43	26.00
27.00	Administrative & General	5.00	2,836,612	405,853	3,242,465	133,967.00	24.20	27.00
28.00	Administrative & General under contract (see inst.)		500,163	0	500,163	2,573.00	194.39	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	571,672	-10,745	560,927	21,652.00	25.91	30.00
31.00	Laundry & Linen Service	8.00	74,473	-1,400	73,073	5,390.00	13.56	31.00
32.00	Housekeeping	9.00	577,008	-10,846	566,162	46,135.00	12.27	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	561,649	-349,737	211,912	9,178.00	23.09	34.00
35.00	Dietary under contract (see instructions)		8,534	0	8,534	160.00	53.34	35.00
36.00	Cafeteria	11.00	0	339,179	339,179	21,989.00	15.42	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	682,450	-12,828	669,622	16,897.00	39.63	38.00
39.00	Central Services and Supply	14.00	125,675	-2,362	123,313	8,152.00	15.13	39.00
40.00	Pharmacy	15.00	509,876	-9,584	500,292	11,997.00	41.70	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part II Date/Time Prepared: 2/25/2015 12:25 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	546,050	-10,264	535,786	30,611.00	17.50	41.00
42.00	Social Service	17.00	64,200	-1,207	62,993	2,085.00	30.21	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part III Date/Time Prepared: 2/25/2015 12:25 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		25,363,133	0	25,363,133	963,555.00	26.32	1.00
2.00	Excluded area salaries (see instructions)		8,401,070	-149,905	8,251,165	280,455.00	29.42	2.00
3.00	Subtotal salaries (line 1 minus line 2)		16,962,063	149,905	17,111,968	683,100.00	25.05	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,120,432	0	1,120,432	13,602.00	82.37	4.00
5.00	Subtotal wage-related costs (see inst.)		4,977,468	0	4,977,468	0.00	29.09	5.00
6.00	Total (sum of lines 3 thru 5)		23,059,963	149,905	23,209,868	696,702.00	33.31	6.00
7.00	Total overhead cost (see instructions)		7,252,654	332,407	7,585,061	316,166.00	23.99	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part IV Date/Time Prepared: 2/25/2015 12:25 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,037,469	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	2,200	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,681,711	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	48,465	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	116	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,726,958	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	18,936	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	44,265	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,560,120	24.00
	Part B - Other than Core Related Cost		
25.00	UNIFORMS	11,389	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part V Date/Time Prepared: 2/25/2015 12:25 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 150045 | Component CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-4 | Date/Time Prepared: 2/25/2015 12:25 pm

Home Health Agency I | PPS

		1.00	
0.00	County	DEKALB	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	211.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99915			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,317	207	61	91	2,676	21.00
22.00	Skilled Nursing Visit Charges	385,140	36,036	8,190	14,924	444,290	22.00
23.00	Physical Therapy Visits	873	61	23	7	964	23.00
24.00	Physical Therapy Visit Charges	154,685	11,002	3,062	1,260	170,009	24.00
25.00	Occupational Therapy Visits	0	0	0	0	0	25.00
26.00	Occupational Therapy Visit Charges	0	0	0	0	0	26.00
27.00	Speech Pathology Visits	50	12	0	0	62	27.00
28.00	Speech Pathology Visit Charges	9,675	2,322	0	0	11,997	28.00
29.00	Medical Social Service Visits	22	2	2	1	27	29.00
30.00	Medical Social Service Visit Charges	6,067	554	554	277	7,452	30.00
31.00	Home Health Aide Visits	943	123	2	38	1,106	31.00
32.00	Home Health Aide Visit Charges	100,050	13,207	217	4,005	117,479	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,205	405	88	137	4,835	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	655,617	63,121	12,023	20,466	751,227	35.00
36.00	Total Number of Episodes (standard/non outlier)	222		22	9	253	36.00
37.00	Total Number of Outlier Episodes		10		1	11	37.00
38.00	Total Non-Routine Medical Supply Charges	17,263	836	351	324	18,774	38.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 150045 Component CCN: 151559	Period: From 10/01/2013 To 09/30/2014	Worksheet S-9 Parts I & II Date/Time Prepared: 2/25/2015 12:25 pm
		Hospice I	

		Unduplicated Days Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	3,253	71	1,176	0	153	3,477	2.00
3.00	Inpatient Respite Care	31	2	0	0	0	33	3.00
4.00	General Inpatient Care	28	0	0	0	1	29	4.00
5.00	Total Hospice Days	3,312	73	1,176	0	154	3,539	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	95	3	25	0	11	109	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	34.86	24.33	47.04	0.00	14.00	32.47	8.00
9.00	Unduplicated Census Count	95	0	0	0	0	95	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/25/2015 12:25 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.350070	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,082,438	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	11,172,869	6.00
7.00	Medicaid cost (line 1 times line 6)	3,911,286	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)	828,848	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	828,848	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,144,158	0	1,144,158	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	400,535	0	400,535	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	400,535	0	400,535	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,891,623	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	87,920	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,803,703	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,681,632	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,082,167	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,911,015	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,744,822	4,744,822	0	4,744,822	1.00
1.01	00101	MAC WEST - NEW		25,115	25,115	0	25,115	1.01
1.02	00102	NORTH ANNEX - NEW		3,966	3,966	0	3,966	1.02
1.03	00103	GARRETT CLINIC - NEW		19,781	19,781	0	19,781	1.03
1.04	00104	BUTLER - NEW		11,914	11,914	0	11,914	1.04
1.05	00105	MAC EAST - NEW		152,791	152,791	0	152,791	1.05
1.06	00106	GARRETT LAB - NEW		0	0	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW		57,252	57,252	0	57,252	1.07
1.08	00108	DAY SPRING - NEW		0	0	0	0	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	194,292	2,620,669	2,814,961	-3,652	2,811,309	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,836,612	6,539,751	9,376,363	390,257	9,766,620	5.00
7.00	00700	OPERATION OF PLANT	571,672	1,329,405	1,901,077	-10,745	1,890,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,473	160,338	234,811	-1,400	233,411	8.00
9.00	00900	HOUSEKEEPING	577,008	373,437	950,445	-10,846	939,599	9.00
10.00	01000	DIETARY	535,234	509,846	1,045,080	-691,854	353,226	10.00
10.01	01001	SNACK BAR	26,415	38,222	64,637	-497	64,140	10.01
11.00	01100	CAFETERIA	0	0	0	681,793	681,793	11.00
13.00	01300	NURSING ADMINISTRATION	682,450	131,785	814,235	-12,828	801,407	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	125,675	142,059	267,734	-2,362	265,372	14.00
15.00	01500	PHARMACY	509,876	0	509,876	-9,584	500,292	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	546,050	102,766	648,816	-10,264	638,552	16.00
17.00	01700	SOCIAL SERVICE	64,200	7,954	72,154	-1,207	70,947	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,462,627	530,614	2,993,241	-840,877	2,152,364	30.00
31.00	03100	INTENSIVE CARE UNIT	912,885	166,232	1,079,117	-17,159	1,061,958	31.00
43.00	04300	NURSERY	0	1,226	1,226	259,924	261,150	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,595,686	1,536,038	3,131,724	-29,993	3,101,731	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	299	299	534,664	534,963	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,605,683	1,217,557	2,823,240	-52,615	2,770,625	54.00
60.00	06000	LABORATORY	1,345,133	1,878,550	3,223,683	-25,284	3,198,399	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	507,438	507,438	0	507,438	65.00
66.00	06600	PHYSICAL THERAPY	346,831	762,709	1,109,540	-54,020	1,055,520	66.00
66.01	06601	CARDIAC REHAB	96,686	19,797	116,483	45,684	162,167	66.01
69.00	06900	ELECTROCARDIOLOGY	61,142	14,728	75,870	21,285	97,155	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	224,832	224,832	0	224,832	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,618,582	1,618,582	0	1,618,582	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	625,452	625,452	0	625,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,879,443	1,879,443	0	1,879,443	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	66,005	20,478	86,483	-1,241	85,242	90.00
91.00	09100	EMERGENCY	1,216,731	711,430	1,928,161	-22,870	1,905,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,149,556	865,641	2,015,197	-21,608	1,993,589	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	894,290	358,661	1,252,951	-2,737	1,250,214	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	111,229	161,822	273,051	-568	272,483	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,608,441	30,073,402	48,681,843	109,396	48,791,239	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	106,105	143,889	249,994	-1,994	248,000	192.00
192.01	19201	DEKALB MEDICAL SERVICES	5,742,553	2,207,746	7,950,299	-107,359	7,842,940	192.01
192.02	19202	PHARMACARE	394,931	3,637,008	4,031,939	0	4,031,939	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	2,406	5,373	7,779	-43	7,736	194.02
200.00		TOTAL (SUM OF LINES 118-199)	24,854,436	36,067,418	60,921,854	0	60,921,854	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-132,931	4,611,891		1.00
1.01	00101	MAC WEST - NEW	0	25,115		1.01
1.02	00102	NORTH ANNEX - NEW	0	3,966		1.02
1.03	00103	GARRETT CLINIC - NEW	0	19,781		1.03
1.04	00104	BUTLER - NEW	0	11,914		1.04
1.05	00105	MAC EAST - NEW	0	152,791		1.05
1.06	00106	GARRETT LAB - NEW	0	0		1.06
1.07	00107	MEDICAL ARTS - NEW	0	57,252		1.07
1.08	00108	DAY SPRING - NEW	0	0		1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-545,846	2,265,463		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,571,522	7,195,098		5.00
7.00	00700	OPERATION OF PLANT	-11,188	1,879,144		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,429	231,982		8.00
9.00	00900	HOUSEKEEPING	-3,614	935,985		9.00
10.00	01000	DIETARY	-5,839	347,387		10.00
10.01	01001	SNACK BAR	-64,140	0		10.01
11.00	01100	CAFETERIA	-254,472	427,321		11.00
13.00	01300	NURSING ADMINISTRATION	0	801,407		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	265,372		14.00
15.00	01500	PHARMACY	0	500,292		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-906	637,646		16.00
17.00	01700	SOCIAL SERVICE	0	70,947		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-5,040	2,147,324		30.00
31.00	03100	INTENSIVE CARE UNIT	-60,400	1,001,558		31.00
43.00	04300	NURSERY	0	261,150		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,097,287	2,004,444		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	534,963		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-21,293	2,749,332		54.00
60.00	06000	LABORATORY	-22,338	3,176,061		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	507,438		65.00
66.00	06600	PHYSICAL THERAPY	-23,122	1,032,398		66.00
66.01	06601	CARDIAC REHAB	-15,665	146,502		66.01
69.00	06900	ELECTROCARDIOLOGY	-11,300	85,855		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	224,832		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,618,582		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	625,452		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-10,332	1,869,111		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	85,242		90.00
91.00	09100	EMERGENCY	-529,514	1,375,777		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-44,350	1,949,239		95.00
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	-52,159	1,198,055		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	-81	272,402		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,484,768	43,306,471		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	248,000		192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	7,842,940		192.01
192.02	19202	PHARMACARE	0	4,031,939		192.02
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0		194.00
194.01	07951	ADULT DAY CARE	0	0		194.01
194.02	07952	FOUNDATION	0	7,736		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-5,484,768	55,437,086		200.00

RECLASSIFICATIONS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/25/2015 12:25 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	339,179	342,614	1.00
	0		339,179	342,614	
	C - LABOR DELIVERY NURSERY				
1.00	NURSERY	43.00	205,488	54,436	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	422,688	111,976	2.00
	0		628,176	166,412	
	E - NORTH ANNEX RECLASS				
1.00	HOME HEALTH AGENCY	101.00	0	14,073	1.00
2.00	HOSPICE	116.00	0	1,523	2.00
	0		0	15,596	
	F - REHABILITATION OFFICE RECLASS				
1.00	CARDIAC REHAB	66.01	46,199	1,302	1.00
	0		46,199	1,302	
	G - RADIOLOGY ADMIN RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	12,344	10,090	1.00
	0		12,344	10,090	
	H - BONUS ACCRUAL RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	405,853	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	0		405,853	0	
500.00	Grand Total: Increases		1,431,751	536,014	500.00

RECLASSIFICATIONS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/25/2015 12:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	339,179	342,614	0		1.00
	0		339,179	342,614			
	C - LABOR DELIVERY NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	628,176	166,412	0		1.00
2.00		0.00	0	0	0		2.00
	0		628,176	166,412			
	E - NORTH ANNEX RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,596	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	15,596			
	F - REHABILITATION OFFICE RECLASS						
1.00	PHYSICAL THERAPY	66.00	46,199	1,302	0		1.00
	0		46,199	1,302			
	G - RADIOLOGY ADMIN RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	12,344	10,090	0		1.00
	0		12,344	10,090			
	H - BONUS ACCRUAL RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3,652	0	0		1.00
2.00	OPERATION OF PLANT	7.00	10,745	0	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	1,400	0	0		3.00
4.00	HOUSEKEEPING	9.00	10,846	0	0		4.00
5.00	DIETARY	10.00	10,061	0	0		5.00
6.00	SNACK BAR	10.01	497	0	0		6.00
7.00	NURSING ADMINISTRATION	13.00	12,828	0	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	2,362	0	0		8.00
9.00	PHARMACY	15.00	9,584	0	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	10,264	0	0		10.00
11.00	SOCIAL SERVICE	17.00	1,207	0	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	46,289	0	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	17,159	0	0		13.00
14.00	OPERATING ROOM	50.00	29,993	0	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	30,181	0	0		15.00
16.00	LABORATORY	60.00	25,284	0	0		16.00
17.00	PHYSICAL THERAPY	66.00	6,519	0	0		17.00
18.00	CARDIAC REHAB	66.01	1,817	0	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	1,149	0	0		19.00
20.00	CLINIC	90.00	1,241	0	0		20.00
21.00	EMERGENCY	91.00	22,870	0	0		21.00
22.00	AMBULANCE SERVICES	95.00	21,608	0	0		22.00
23.00	HOME HEALTH AGENCY	101.00	16,810	0	0		23.00
24.00	HOSPICE	116.00	2,091	0	0		24.00
25.00	PHYSICIANS PRIVATE OFFICES	192.00	1,994	0	0		25.00
26.00	DEKALB MEDICAL SERVICES	192.01	107,359	0	0		26.00
27.00	FOUNDATION	194.02	43	0	0		27.00
	0		405,853	0			
500.00	Grand Total: Decreases		1,431,751	536,014			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2015 12:25 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	393,118	0	0	0	0	1.00
2.00	Land Improvements	1,699,339	0	0	0	7,039	2.00
3.00	Buildings and Fixtures	52,726,620	872,920	0	872,920	869,983	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	20,947,606	6,410,826	0	6,410,826	3,595,266	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,766,683	7,283,746	0	7,283,746	4,472,288	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	75,766,683	7,283,746	0	7,283,746	4,472,288	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	393,118	0	1.00
2.00	Land Improvements	1,692,300	0	2.00
3.00	Buildings and Fixtures	52,729,557	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	23,763,166	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,578,141	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	78,578,141	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/25/2015 12:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,390,725	0	354,097	0	0	1.00
1.01	MAC WEST - NEW	25,115	0	0	0	0	1.01
1.02	NORTH ANNEX - NEW	3,966	0	0	0	0	1.02
1.03	GARRETT CLINIC - NEW	19,781	0	0	0	0	1.03
1.04	BUTLER - NEW	11,914	0	0	0	0	1.04
1.05	MAC EAST - NEW	152,791	0	0	0	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	57,252	0	0	0	0	1.07
1.08	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,661,544	0	354,097	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	4,744,822	1.00
1.01	MAC WEST - NEW	0	25,115	1.01
1.02	NORTH ANNEX - NEW	0	3,966	1.02
1.03	GARRETT CLINIC - NEW	0	19,781	1.03
1.04	BUTLER - NEW	0	11,914	1.04
1.05	MAC EAST - NEW	0	152,791	1.05
1.06	GARRETT LAB - NEW	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	57,252	1.07
1.08	DAY SPRING - NEW	0	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	5,015,641	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III | Date/Time Prepared: 2/25/2015 12:25 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
1.01	MAC WEST - NEW	0	0	0	0.000000	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0.000000	0	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	0.000000	0	1.03
1.04	BUTLER - NEW	0	0	0	0.000000	0	1.04
1.05	MAC EAST - NEW	0	0	0	0.000000	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0.000000	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0.000000	0	1.07
1.08	DAY SPRING - NEW	0	0	0	0.000000	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,389,870	0	1.00
1.01	MAC WEST - NEW	0	0	0	25,115	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	3,966	0	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	19,781	0	1.03
1.04	BUTLER - NEW	0	0	0	11,914	0	1.04
1.05	MAC EAST - NEW	0	0	0	152,791	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	57,252	0	1.07
1.08	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,660,689	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	222,021	0	0	0	4,611,891	1.00
1.01	MAC WEST - NEW	0	0	0	0	25,115	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0	3,966	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	0	19,781	1.03
1.04	BUTLER - NEW	0	0	0	0	11,914	1.04
1.05	MAC EAST - NEW	0	0	0	0	152,791	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0	57,252	1.07
1.08	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	222,021	0	0	0	4,882,710	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/25/2015 12:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-132,076	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - MAC WEST - NEW (chapter 2)		0	MAC WEST - NEW	1.01	0	1.01
1.02	Investment income - NORTH ANNEX - NEW (chapter 2)		0	NORTH ANNEX - NEW	1.02	0	1.02
1.03	Investment income - GARRETT CLINIC - NEW (chapter 2)		0	GARRETT CLINIC - NEW	1.03	0	1.03
1.04	Investment income - BUTLER - NEW (chapter 2)		0	BUTLER - NEW	1.04	0	1.04
1.05	Investment income - MAC EAST - NEW (chapter 2)		0	MAC EAST - NEW	1.05	0	1.05
1.06	Investment income - GARRETT LAB - NEW (chapter 2)		0	GARRETT LAB - NEW	1.06	0	1.06
1.07	Investment income - MEDICAL ARTS - NEW (chapter 2)		0	MEDICAL ARTS - NEW	1.07	0	1.07
1.08	Investment income - DAY SPRING - NEW (chapter 2)		0	DAY SPRING - NEW	1.08	0	1.08
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,740,324			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	0			0	12.00
13.00	Laundry and linen service	B	-1,429	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-254,472	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	-8,297	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-906	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	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/25/2015 12:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
26.01	Depreciation - MAC WEST - NEW		0	MAC WEST - NEW	1.01	0	26.01
26.02	Depreciation - NORTH ANNEX - NEW		0	NORTH ANNEX - NEW	1.02	0	26.02
26.03	Depreciation - GARRETT CLINIC - NEW		0	GARRETT CLINIC - NEW	1.03	0	26.03
26.04	Depreciation - BUTLER - NEW		0	BUTLER - NEW	1.04	0	26.04
26.05	Depreciation - MAC EAST - NEW		0	MAC EAST - NEW	1.05	0	26.05
26.06	Depreciation - GARRETT LAB - NEW		0	GARRETT LAB - NEW	1.06	0	26.06
26.07	Depreciation - MEDICAL ARTS - NEW		0	MEDICAL ARTS - NEW	1.07	0	26.07
26.08	Depreciation - DAY SPRING - NEW		0	DAY SPRING - NEW	1.08	0	26.08
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-210	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-103,087	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.05	WASTE DISPOSAL REVENUE	B	-356	OPERATION OF PLANT	7.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-10,832	OPERATION OF PLANT	7.00	0	33.06
33.07	HOUSEKEEPING INCOME	B	-3,614	HOUSEKEEPING	9.00	0	33.07
33.08	OBSTETRICS MISCELLANEOUS INCOME	B	-40	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	RADIOLOGY NON-PATIENT REVENUE	B	-5,187	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	NON-PATIENT LAB REVENUE	B	-22,338	LABORATORY	60.00	0	33.10
33.11	MISCELLANEOUS INCOME	B	-14,641	CARDIAC REHAB	66.01	0	33.11
33.12	MISCELLANEOUS INCOME	B	-2,035	DRUGS CHARGED TO PATIENTS	73.00	0	33.12
33.13	AMBULANCE SERVICE REVENUE	B	-44,350	AMBULANCE SERVICES	95.00	0	33.13
33.15	DIABETES SERVICE MISC INCOME	B	-5,839	DIETARY	10.00	0	33.15
33.16	HOME HEALTH MISCELLANEOUS INCOME	B	-51,773	HOME HEALTH AGENCY	101.00	0	33.16
33.18	LOBBYING PORTION OF IHA & AHA DUES	A	-6,135	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	LOBBYING PORTION OF IAHHC DUES - HOS	A	-33	HOSPICE	116.00	0	33.19
33.20	LOBBYING PORTION OF IAHHC DUES - HHA	A	-50	HOME HEALTH AGENCY	101.00	0	33.20
33.23	NON-ALLOWABLE MARKETING	A	-402,210	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24	NON-ALLOWABLE MARKETING	A	-1,150	RADIOLOGY-DIAGNOSTIC	54.00	0	33.24
33.25	NON-ALLOWABLE MARKETING	A	-16,024	PHYSICAL THERAPY	66.00	0	33.25
33.26	NON-ALLOWABLE MARKETING	A	-336	HOME HEALTH AGENCY	101.00	0	33.26
33.27	NON-ALLOWABLE MARKETING	A	-48	HOSPICE	116.00	0	33.27
33.28	NON-ALLOWABLE MARKETING	A	-1,024	CARDIAC REHAB	66.01	0	33.28
33.31	LIFELINE EXPENSES - DEPRECIATION	A	-855	CAP REL COSTS-BLDG & FIXT	1.00	9	33.31
33.32	FLOWER/GIFTS	A	-6,037	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	SELF-INSURANCE EXPENSES	A	-545,636	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.33
33.37	PHYSICIAN RECRUITMENT	A	-20,415	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	THERAPY MISCELLANEOUS REVENUE	A	-7,098	PHYSICAL THERAPY	66.00	0	33.38
33.39	HAF FEE	A	-2,043,426	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	SNACK BAR	A	-64,140	SNACK BAR	10.01	0	33.40
33.41	INVESTMENT MANAGEMENT FEE	B	31,655	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42			0		0.00	0	33.42
33.43			0		0.00	0	33.43
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,484,768				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

ADJUSTMENTS TO EXPENSES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/25/2015 12:25 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

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.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2015 12:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	35,413	0	35,413	177,200	159	1.00
2.00	31.00	INTENSIVE CARE UNIT	50,400	50,400	0	177,200	0	2.00
3.00	50.00	OPERATING ROOM	1,094,537	1,094,537	0	177,200	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	99,485	13,918	84,529	177,200	1,197	4.00
5.00	69.00	ELECTROCARDIOLOGY	11,300	11,300	0	177,200	0	5.00
6.00	91.00	EMERGENCY	529,014	529,014	0	177,200	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	5,000	5,000	0	177,200	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	10,000	10,000	0	177,200	0	8.00
9.00	50.00	OPERATING ROOM	2,750	2,750	0	177,200	0	9.00
10.00	91.00	EMERGENCY	500	500	0	177,200	0	10.00
200.00			1,838,399	1,717,419	119,942		1,356	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	13,546	677	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	101,975	5,099	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			115,521	5,776	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	13,546	21,867	21,867		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	50,400		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,094,537		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	101,975	0	14,956		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	11,300		5.00
6.00	91.00	EMERGENCY	0	0	0	529,014		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	5,000		7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	10,000		8.00
9.00	50.00	OPERATING ROOM	0	0	0	2,750		9.00
10.00	91.00	EMERGENCY	0	0	0	500		10.00
200.00			0	115,521	21,867	1,740,324		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,611,891	4,611,891				1.00
1.01	00101	MAC WEST - NEW	25,115	0	25,115			1.01
1.02	00102	NORTH ANNEX - NEW	3,966	0	0	3,966		1.02
1.03	00103	GARRETT CLINIC - NEW	19,781	0	0	0	19,781	1.03
1.04	00104	BUTLER - NEW	11,914	0	0	0	0	1.04
1.05	00105	MAC EAST - NEW	152,791	0	0	0	0	1.05
1.06	00106	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW	57,252	0	0	0	0	1.07
1.08	00108	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,265,463	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,195,098	595,075	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	1,879,144	1,853,695	4,507	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	231,982	27,600	0	0	0	8.00
9.00	00900	HOUSEKEEPING	935,985	44,128	0	0	0	9.00
10.00	01000	DIETARY	347,387	23,162	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	427,321	54,484	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	801,407	24,503	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	265,372	29,103	0	0	0	14.00
15.00	01500	PHARMACY	500,292	26,768	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	637,646	64,609	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	70,947	3,791	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,147,324	271,058	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,001,558	115,094	0	0	0	31.00
43.00	04300	NURSERY	261,150	37,355	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,004,444	410,100	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	534,963	113,916	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,749,332	215,325	0	0	0	54.00
60.00	06000	LABORATORY	3,176,061	96,833	1,021	0	4,136	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	507,438	25,243	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,032,398	120,573	0	0	0	66.00
66.01	06601	CARDIAC REHAB	146,502	63,453	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	85,855	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	224,832	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,618,582	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	625,452	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,869,111	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	85,242	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,375,777	177,369	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,949,239	100,739	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,198,055	0	0	3,579	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	272,402	0	0	387	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,306,471	4,493,976	5,528	3,966	4,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	248,000	117,915	17,885	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	7,842,940	0	1,702	0	15,645	192.01
192.02	19202	PHARMACARE	4,031,939	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	7,736	0	0	0	0	194.02
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)	55,437,086	4,611,891	25,115	3,966	19,781	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	
			1.04	1.05	1.06	1.07	1.08	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW	11,914					1.04
1.05	00105	MAC EAST - NEW	0	152,791				1.05
1.06	00106	GARRETT LAB - NEW	0	0	0			1.06
1.07	00107	MEDICAL ARTS - NEW	0	0	0	57,252		1.07
1.08	00108	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	20,460	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	45,412	0	4,540	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	310	0	0	0	9.00
10.00	01000	DIETARY	0	832	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,158	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	843	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	843	68,172	0	4,540	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	52,778	0	43,699	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	11,071	31,841	0	9,013	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	11,914	152,791	0	57,252	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			2.00	4.00	4A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,265,463				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	297,833	8,108,466	8,108,466		5.00
7.00	00700	OPERATION OF PLANT	0	51,523	3,838,821	657,678	4,496,499	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,712	266,294	45,622	36,277	8.00
9.00	00900	HOUSEKEEPING	0	52,004	1,032,427	176,878	60,309	9.00
10.00	01000	DIETARY	0	17,084	388,465	66,553	36,641	10.00
10.01	01001	SNACK BAR	0	2,381	2,381	408	0	10.01
11.00	01100	CAFETERIA	0	31,155	512,960	87,882	71,612	11.00
13.00	01300	NURSING ADMINISTRATION	0	61,507	887,417	152,035	32,206	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,327	305,802	52,391	38,252	14.00
15.00	01500	PHARMACY	0	45,954	573,014	98,170	35,183	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,214	752,627	128,942	93,548	16.00
17.00	01700	SOCIAL SERVICE	0	5,786	80,524	13,796	4,983	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	164,250	2,582,632	442,464	356,266	30.00
31.00	03100	INTENSIVE CARE UNIT	0	82,276	1,198,928	205,404	151,275	31.00
43.00	04300	NURSERY	0	18,875	317,380	54,374	49,098	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	143,815	2,558,359	438,306	539,017	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	38,826	687,705	117,820	149,725	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	143,582	3,108,239	532,513	283,014	54.00
60.00	06000	LABORATORY	0	121,233	3,400,127	582,520	181,961	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	532,681	91,261	33,178	65.00
66.00	06600	PHYSICAL THERAPY	0	27,015	1,179,986	202,159	158,475	66.00
66.01	06601	CARDIAC REHAB	0	12,958	222,913	38,190	83,400	66.01
69.00	06900	ELECTROCARDIOLOGY	0	6,644	92,499	15,847	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	224,832	38,519	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,618,582	277,300	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	625,452	107,154	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,869,111	320,222	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,949	91,191	15,623	0	90.00
91.00	09100	EMERGENCY	0	109,661	1,662,807	284,877	233,125	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	103,607	2,153,585	368,959	132,407	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	80,600	1,282,234	219,676	84,220	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	10,025	282,814	48,453	9,115	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,701,796	42,441,255	5,881,996	2,853,287	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	9,563	489,840	83,921	1,100,610	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	517,611	8,429,823	1,444,207	542,602	192.01
192.02	19202	PHARMACARE	0	36,276	4,068,215	696,979	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	217	7,953	1,363	0	194.02
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)	0	2,265,463	55,437,086	8,108,466	4,496,499	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	
			8.00	9.00	10.00	10.01	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	348,193					8.00
9.00	00900	HOUSEKEEPING	20,200	1,289,814				9.00
10.00	01000	DIETARY	0	10,741	502,400			10.00
10.01	01001	SNACK BAR	0	0	0	2,789		10.01
11.00	01100	CAFETERIA	0	20,993	0	2,789	696,236	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,441	0	0	18,358	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,213	0	0	8,863	14.00
15.00	01500	PHARMACY	0	10,314	0	0	13,045	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,423	0	0	33,280	16.00
17.00	01700	SOCIAL SERVICE	0	1,461	0	0	2,261	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	130,385	104,438	397,133	0	83,607	30.00
31.00	03100	INTENSIVE CARE UNIT	32,000	44,346	105,267	0	37,146	31.00
43.00	04300	NURSERY	4,465	14,393	0	0	7,845	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,452	158,010	0	0	57,833	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	43,891	0	0	16,120	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,666	82,964	0	0	58,127	54.00
60.00	06000	LABORATORY	0	53,341	0	0	57,924	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	3,561	9,726	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,998	46,456	0	0	13,927	66.00
66.01	06601	CARDIAC REHAB	1,176	24,448	0	0	7,077	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3,866	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,068	0	0	0	2,803	90.00
91.00	09100	EMERGENCY	51,623	68,340	0	0	45,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,696	38,815	0	0	57,607	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	24,689	0	0	41,555	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	136	2,672	0	0	3,753	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	344,426	808,115	502,400	2,789	570,667	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	322,638	0	0	13,181	192.00
192.01	19201	DEKALB MEDICAL SERVICES	3,767	159,061	0	0	111,303	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	1,085	194.02
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)	348,193	1,289,814	502,400	2,789	696,236	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
10.01	01001	SNACK BAR						10.01
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,099,457					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,118	447,639				14.00
15.00	01500	PHARMACY	0	0	729,726			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,035,820		16.00
17.00	01700	SOCIAL SERVICE	7,959	0	0	0	110,984	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	293,644	0	0	103,673	110,984	30.00
31.00	03100	INTENSIVE CARE UNIT	130,414	0	0	42,250	0	31.00
43.00	04300	NURSERY	27,530	0	0	10,389	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	203,074	0	0	214,576	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,628	0	0	21,445	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	186,554	0	54.00
60.00	06000	LABORATORY	19,735	0	0	171,227	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	26,205	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	34,033	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	3,866	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,283	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	11,934	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	447,639	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	729,726	151	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,864	0	0	3,388	0	90.00
91.00	09100	EMERGENCY	160,410	0	0	93,911	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	145,923	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	13,158	0	0	5,986	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,099,457	447,639	729,726	937,871	110,984	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	0	97,949	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	1,099,457	447,639	729,726	1,035,820	110,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
10.01	01001	SNACK BAR					10.01
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,605,226	0	4,605,226		30.00
31.00	03100	INTENSIVE CARE UNIT	1,947,030	0	1,947,030		31.00
43.00	04300	NURSERY	485,474	0	485,474		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,220,627	0	4,220,627		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093,334	0	1,093,334		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,287,077	0	4,287,077		54.00
60.00	06000	LABORATORY	4,466,835	0	4,466,835		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	696,612	0	696,612		65.00
66.00	06600	PHYSICAL THERAPY	1,642,034	0	1,642,034		66.00
66.01	06601	CARDIAC REHAB	381,070	0	381,070		66.01
69.00	06900	ELECTROCARDIOLOGY	120,495	0	120,495		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	275,285	0	275,285		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,343,521	0	2,343,521		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	732,606	0	732,606		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,919,210	0	2,919,210		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	124,937	0	124,937		90.00
91.00	09100	EMERGENCY	2,600,763	0	2,600,763		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	2,756,069	0	2,756,069		95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	1,798,297	0	1,798,297		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	366,087	0	366,087		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,862,589	0	37,862,589		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,010,190	0	2,010,190		192.00
192.01	19201	DEKALB MEDICAL SERVICES	10,788,712	0	10,788,712		192.01
192.02	19202	PHARMACARE	4,765,194	0	4,765,194		192.02
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0		194.00
194.01	07951	ADULT DAY CARE	0	0	0		194.01
194.02	07952	FOUNDATION	10,401	0	10,401		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	55,437,086	0	55,437,086		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	
			0	1.00	1.01	1.02	1.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	595,075	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	1,853,695	4,507	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,600	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	44,128	0	0	0	9.00
10.00	01000	DIETARY	0	23,162	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	54,484	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,503	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,103	0	0	0	14.00
15.00	01500	PHARMACY	0	26,768	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,609	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,791	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	271,058	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	115,094	0	0	0	31.00
43.00	04300	NURSERY	0	37,355	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	410,100	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	113,916	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	215,325	0	0	0	54.00
60.00	06000	LABORATORY	0	96,833	1,021	0	4,136	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	25,243	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	120,573	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	63,453	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	177,369	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	100,739	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	3,579	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	387	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,493,976	5,528	3,966	4,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	117,915	17,885	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	1,702	0	15,645	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	0	4,611,891	25,115	3,966	19,781	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	
			1.04	1.05	1.06	1.07	1.08	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	20,460	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	45,412	0	4,540	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	310	0	0	0	9.00
10.00	01000	DIETARY	0	832	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,158	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	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
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	843	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	843	68,172	0	4,540	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	52,778	0	43,699	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	11,071	31,841	0	9,013	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	11,914	152,791	0	57,252	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
			2.00	2A	4.00	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	615,535	0	615,535		5.00
7.00	00700	OPERATION OF PLANT	0	1,908,154	0	49,928	1,958,082	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,600	0	3,463	15,797	8.00
9.00	00900	HOUSEKEEPING	0	44,438	0	13,428	26,263	9.00
10.00	01000	DIETARY	0	23,994	0	5,052	15,956	10.00
10.01	01001	SNACK BAR	0	0	0	31	0	10.01
11.00	01100	CAFETERIA	0	54,484	0	6,672	31,185	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,503	0	11,542	14,024	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,103	0	3,977	16,657	14.00
15.00	01500	PHARMACY	0	26,768	0	7,453	15,321	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65,767	0	9,789	40,737	16.00
17.00	01700	SOCIAL SERVICE	0	3,791	0	1,047	2,170	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	271,058	0	33,590	155,142	30.00
31.00	03100	INTENSIVE CARE UNIT	0	115,094	0	15,593	65,875	31.00
43.00	04300	NURSERY	0	37,355	0	4,128	21,381	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	410,100	0	33,274	234,725	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	113,916	0	8,944	65,201	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	215,325	0	40,426	123,243	54.00
60.00	06000	LABORATORY	0	102,833	0	44,222	79,238	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	25,243	0	6,928	14,448	65.00
66.00	06600	PHYSICAL THERAPY	0	120,573	0	15,347	69,011	66.00
66.01	06601	CARDIAC REHAB	0	63,453	0	2,899	36,318	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,203	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,924	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	21,051	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,135	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,310	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,186	0	90.00
91.00	09100	EMERGENCY	0	177,369	0	21,626	101,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	100,739	0	28,010	57,659	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	3,579	0	16,677	36,675	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	387	0	3,678	3,969	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,581,161	0	446,533	1,242,514	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	232,277	0	6,371	479,282	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	69,272	0	109,617	236,286	192.01
192.02	19202	PHARMACARE	0	0	0	52,911	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	103	0	194.02
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)	0	4,882,710	0	615,535	1,958,082	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	
			8.00	9.00	10.00	10.01	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,860					8.00
9.00	00900	HOUSEKEEPING	2,719	86,848				9.00
10.00	01000	DIETARY	0	723	45,725			10.00
10.01	01001	SNACK BAR	0	0	0	31		10.01
11.00	01100	CAFETERIA	0	1,414	0	31	93,786	11.00
13.00	01300	NURSING ADMINISTRATION	0	636	0	0	2,473	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	755	0	0	1,194	14.00
15.00	01500	PHARMACY	0	694	0	0	1,757	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,847	0	0	4,483	16.00
17.00	01700	SOCIAL SERVICE	0	98	0	0	305	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,548	7,032	36,144	0	11,262	30.00
31.00	03100	INTENSIVE CARE UNIT	4,307	2,986	9,581	0	5,004	31.00
43.00	04300	NURSERY	601	969	0	0	1,057	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,924	10,639	0	0	7,790	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,955	0	0	2,171	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,800	5,586	0	0	7,830	54.00
60.00	06000	LABORATORY	0	3,592	0	0	7,803	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	479	655	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	942	3,128	0	0	1,876	66.00
66.01	06601	CARDIAC REHAB	158	1,646	0	0	953	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	521	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	278	0	0	0	378	90.00
91.00	09100	EMERGENCY	6,947	4,602	0	0	6,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	632	2,614	0	0	7,760	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,662	0	0	5,598	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	18	180	0	0	506	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	46,353	54,413	45,725	31	76,873	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	21,725	0	0	1,776	192.00
192.01	19201	DEKALB MEDICAL SERVICES	507	10,710	0	0	14,991	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	146	194.02
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)	46,860	86,848	45,725	31	93,786	202.00

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		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
10.01	01001	SNACK BAR						10.01
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	53,178					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,505	53,191				14.00
15.00	01500	PHARMACY	0	0	51,993			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	122,623		16.00
17.00	01700	SOCIAL SERVICE	385	0	0	0	7,796	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,202	0	0	12,268	7,796	30.00
31.00	03100	INTENSIVE CARE UNIT	6,308	0	0	5,000	0	31.00
43.00	04300	NURSERY	1,332	0	0	1,229	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,822	0	0	25,442	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,739	0	0	2,538	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,076	0	54.00
60.00	06000	LABORATORY	955	0	0	20,262	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,101	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,027	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	457	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	980	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,412	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	53,191	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	51,993	18	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	477	0	0	401	0	90.00
91.00	09100	EMERGENCY	7,759	0	0	11,113	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	7,058	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	636	0	0	708	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,178	53,191	51,993	111,032	7,796	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	0	11,591	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	53,178	53,191	51,993	122,623	7,796	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MAC WEST - NEW					1.01
1.02	00102	NORTH ANNEX - NEW					1.02
1.03	00103	GARRETT CLINIC - NEW					1.03
1.04	00104	BUTLER - NEW					1.04
1.05	00105	MAC EAST - NEW					1.05
1.06	00106	GARRETT LAB - NEW					1.06
1.07	00107	MEDICAL ARTS - NEW					1.07
1.08	00108	DAY SPRING - NEW					1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
10.01	01001	SNACK BAR					10.01
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	566,042	0	566,042		30.00
31.00	03100	INTENSIVE CARE UNIT	229,748	0	229,748		31.00
43.00	04300	NURSERY	68,052	0	68,052		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	738,716	0	738,716		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	198,464	0	198,464		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,286	0	419,286		54.00
60.00	06000	LABORATORY	258,905	0	258,905		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	50,854	0	50,854		65.00
66.00	06600	PHYSICAL THERAPY	214,904	0	214,904		66.00
66.01	06601	CARDIAC REHAB	105,884	0	105,884		66.01
69.00	06900	ELECTROCARDIOLOGY	2,704	0	2,704		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,336	0	4,336		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	74,242	0	74,242		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,135	0	8,135		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,321	0	76,321		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,720	0	2,720		90.00
91.00	09100	EMERGENCY	337,087	0	337,087		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	197,414	0	197,414		95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	71,249	0	71,249		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	10,082	0	10,082		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,635,145	0	3,635,145		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	741,431	0	741,431		192.00
192.01	19201	DEKALB MEDICAL SERVICES	452,974	0	452,974		192.01
192.02	19202	PHARMACARE	52,911	0	52,911		192.02
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0		194.00
194.01	07951	ADULT DAY CARE	0	0	0		194.01
194.02	07952	FOUNDATION	249	0	249		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,882,710	0	4,882,710		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)	BUTLER - NEW (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	199,511					1.00
1.01	00101	MAC WEST - NEW	0	16,334				1.01
1.02	00102	NORTH ANNEX - NEW	0	0	3,072			1.02
1.03	00103	GARRETT CLINIC - NEW	0	0	0	3,750		1.03
1.04	00104	BUTLER - NEW	0	0	0	0	4,977	1.04
1.05	00105	MAC EAST - NEW	0	0	0	0	0	1.05
1.06	00106	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW	0	0	0	0	0	1.07
1.08	00108	DAY SPRING - NEW	0	0	0	0	0	1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,743	0	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	80,191	2,931	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,194	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,909	0	0	0	0	9.00
10.00	01000	DIETARY	1,002	0	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	2,357	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,060	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	0	0	0	0	14.00
15.00	01500	PHARMACY	1,158	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,795	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,726	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,979	0	0	0	0	31.00
43.00	04300	NURSERY	1,616	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,741	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,928	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,315	0	0	0	0	54.00
60.00	06000	LABORATORY	4,189	664	0	784	352	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,092	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,216	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	2,745	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,673	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,358	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	2,772	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	300	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	194,410	3,595	3,072	784	352	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	5,101	11,632	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	1,107	0	2,966	4,625	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,611,891	25,115	3,966	19,781	11,914	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.115974	1.537590	1.291016	5.274933	2.393812	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)	BUTLER - NEW (SQUARE FEET)	
			1.00	1.01	1.02	1.03	1.04	
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			MAC EAST - NEW (SQUARE FEET)	GARRETT LAB - NEW (SQUARE FEET)	MEDICAL ARTS - NEW (SQUARE FEET)	DAY SPRING - NEW (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	
			1.05	1.06	1.07	1.08	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW	37,481					1.05
1.06	00106	GARRETT LAB - NEW	0	0				1.06
1.07	00107	MEDICAL ARTS - NEW	0	0	8,575			1.07
1.08	00108	DAY SPRING - NEW	0	0	0	0		1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP					199,511	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,019	0	0	0	25,743	5.00
7.00	00700	OPERATION OF PLANT	11,140	0	680	0	80,191	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	1,194	8.00
9.00	00900	HOUSEKEEPING	76	0	0	0	1,909	9.00
10.00	01000	DIETARY	204	0	0	0	1,002	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	0	0	0	2,357	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	1,060	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,259	14.00
15.00	01500	PHARMACY	0	0	0	0	1,158	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	284	0	0	0	2,795	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	164	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	11,726	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	4,979	31.00
43.00	04300	NURSERY	0	0	0	0	1,616	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	17,741	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	4,928	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	9,315	54.00
60.00	06000	LABORATORY	0	0	0	0	4,189	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1,092	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	5,216	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	2,745	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	7,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	4,358	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,723	0	680	0	194,410	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	12,947	0	6,545	0	5,101	192.00
192.01	19201	DEKALB MEDICAL SERVICES	7,811	0	1,350	0	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
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)	152,791	0	57,252	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.076492	0.000000	6.676618	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			MAC EAST - NEW (SQUARE FEET)	GARRETT LAB - NEW (SQUARE FEET)	MEDICAL ARTS - NEW (SQUARE FEET)	DAY SPRING - NEW (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	
			1.05	1.06	1.07	1.08	2.00	
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			4.00	5A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	24,663,796					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,242,465	-8,108,466	47,328,620			5.00
7.00	00700	OPERATION OF PLANT	560,927	0	3,838,821	147,996		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,073	0	266,294	1,194	311,386	8.00
9.00	00900	HOUSEKEEPING	566,162	0	1,032,427	1,985	18,065	9.00
10.00	01000	DIETARY	185,994	0	388,465	1,206	0	10.00
10.01	01001	SNACK BAR	25,918	0	2,381	0	0	10.01
11.00	01100	CAFETERIA	339,179	0	512,960	2,357	0	11.00
13.00	01300	NURSING ADMINISTRATION	669,622	0	887,417	1,060	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	123,313	0	305,802	1,259	0	14.00
15.00	01500	PHARMACY	500,292	0	573,014	1,158	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	535,786	0	752,627	3,079	0	16.00
17.00	01700	SOCIAL SERVICE	62,993	0	80,524	164	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,788,162	0	2,582,632	11,726	116,601	30.00
31.00	03100	INTENSIVE CARE UNIT	895,726	0	1,198,928	4,979	28,617	31.00
43.00	04300	NURSERY	205,488	0	317,380	1,616	3,993	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,565,693	0	2,558,359	17,741	46,013	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	422,688	0	687,705	4,928	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,563,158	0	3,108,239	9,315	31,896	54.00
60.00	06000	LABORATORY	1,319,849	0	3,400,127	5,989	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	532,681	1,092	3,185	65.00
66.00	06600	PHYSICAL THERAPY	294,113	0	1,179,986	5,216	6,258	66.00
66.01	06601	CARDIAC REHAB	141,068	0	222,913	2,745	1,052	66.01
69.00	06900	ELECTROCARDIOLOGY	72,337	0	92,499	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	224,832	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,618,582	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	625,452	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,869,111	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	64,764	0	91,191	0	1,849	90.00
91.00	09100	EMERGENCY	1,193,861	0	1,662,807	7,673	46,166	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,127,948	0	2,153,585	4,358	4,200	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	877,480	0	1,282,234	2,772	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	109,138	0	282,814	300	122	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,527,197	-8,108,466	34,332,789	93,912	308,017	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	104,111	0	489,840	36,225	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	5,635,194	0	8,429,823	17,859	3,369	192.01
192.02	19202	PHARMACARE	394,931	0	4,068,215	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	2,363	0	7,953	0	0	194.02
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)	2,265,463		8,108,466	4,496,499	348,193	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.091854		0.171323	30.382571	1.118204	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		615,535	1,958,082	46,860	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			4.00	5A	5.00	7.00	8.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.013006	13.230641	0.150488	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	
			9.00	10.00	10.01	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	144,817					9.00
10.00	01000	DIETARY	1,206	23,381				10.00
10.01	01001	SNACK BAR	0	0	1			10.01
11.00	01100	CAFETERIA	2,357	0	1	30,795		11.00
13.00	01300	NURSING ADMINISTRATION	1,060	0	0	812	288,028	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	0	0	392	8,152	14.00
15.00	01500	PHARMACY	1,158	0	0	577	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,079	0	0	1,472	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	0	100	2,085	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,726	18,482	0	3,698	76,927	30.00
31.00	03100	INTENSIVE CARE UNIT	4,979	4,899	0	1,643	34,165	31.00
43.00	04300	NURSERY	1,616	0	0	347	7,212	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,741	0	0	2,558	53,200	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,928	0	0	713	14,835	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,315	0	0	2,571	0	54.00
60.00	06000	LABORATORY	5,989	0	0	2,562	5,170	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,092	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,216	0	0	616	0	66.00
66.01	06601	CARDIAC REHAB	2,745	0	0	313	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	171	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	124	2,584	90.00
91.00	09100	EMERGENCY	7,673	0	0	2,020	42,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,358	0	0	2,548	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,772	0	0	1,838	38,228	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	300	0	0	166	3,447	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,733	23,381	1	25,241	288,028	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	36,225	0	0	583	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	17,859	0	0	4,923	0	192.01
192.02	19202	PHARMACARE	0	0	0	0	0	192.02
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0	0	194.00
194.01	07951	ADULT DAY CARE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	48	0	194.02
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)	1,289,814	502,400	2,789	696,236	1,099,457	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.906510	21.487533	2,789.000000	22.608735	3.817188	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	86,848	45,725	31	93,786	53,178	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	
			9.00	10.00	10.01	11.00	13.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.599709	1.955648	31.000000	3.045494	0.184628	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			14.00	15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
10.01	01001	SNACK BAR						10.01
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	103,617,181			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	100		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	10,370,365	100		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	4,226,284	0		31.00
43.00	04300	NURSERY	0	0	1,039,220	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	21,468,206	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	2,145,142	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	18,661,013	0		54.00
60.00	06000	LABORATORY	0	0	17,127,841	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	2,621,276	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,404,275	0		66.00
66.01	06601	CARDIAC REHAB	0	0	386,689	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	828,581	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,193,725	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	100	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	15,111	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	338,920	0		90.00
91.00	09100	EMERGENCY	0	0	9,393,913	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	598,796	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	93,819,357	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	9,797,824	0		192.01
192.02	19202	PHARMACARE	0	0	0	0		192.02
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENT	0	0	0	0		194.00
194.01	07951	ADULT DAY CARE	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
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)	447,639	729,726	1,035,820	110,984		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4,476.390000	7,297.260000	0.009997	1,109.840000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,191	51,993	122,623	7,796		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			14.00	15.00	16.00	17.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	531.910000	519.930000	0.001183	77.960000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,605,226		4,605,226	0	4,605,226	30.00
31.00	03100	INTENSIVE CARE UNIT	1,947,030		1,947,030	0	1,947,030	31.00
43.00	04300	NURSERY	485,474		485,474	0	485,474	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,220,627		4,220,627	0	4,220,627	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093,334		1,093,334	0	1,093,334	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,287,077		4,287,077	0	4,287,077	54.00
60.00	06000	LABORATORY	4,466,835		4,466,835	0	4,466,835	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	696,612	0	696,612	0	696,612	65.00
66.00	06600	PHYSICAL THERAPY	1,642,034	0	1,642,034	0	1,642,034	66.00
66.01	06601	CARDIAC REHAB	381,070	0	381,070	0	381,070	66.01
69.00	06900	ELECTROCARDIOLOGY	120,495		120,495	0	120,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	275,285		275,285	0	275,285	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,343,521		2,343,521	0	2,343,521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	732,606		732,606	0	732,606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,919,210		2,919,210	0	2,919,210	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	124,937		124,937	0	124,937	90.00
91.00	09100	EMERGENCY	2,600,763		2,600,763	0	2,600,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	629,107		629,107		629,107	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,756,069		2,756,069	0	2,756,069	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,798,297		1,798,297		1,798,297	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	366,087		366,087		366,087	116.00
200.00		Subtotal (see instructions)	38,491,696	0	38,491,696	0	38,491,696	200.00
201.00		Less Observation Beds	629,107		629,107		629,107	201.00
202.00		Total (see instructions)	37,862,589	0	37,862,589	0	37,862,589	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,111,676		9,111,676			30.00
31.00	03100	INTENSIVE CARE UNIT	3,886,417		3,886,417			31.00
43.00	04300	NURSERY	1,024,522		1,024,522			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,998,195	12,089,165	15,087,360	0.279746	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,109,626	11,121	2,120,747	0.515542	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,391,810	16,827,159	18,218,969	0.235308	0.000000	54.00
60.00	06000	LABORATORY	2,714,099	17,082,167	19,796,266	0.225640	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,578,512	458,300	2,036,812	0.342011	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	512,754	2,842,474	3,355,228	0.489396	0.000000	66.00
66.01	06601	CARDIAC REHAB	4,177	376,521	380,698	1.000977	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	161,404	655,523	816,927	0.147498	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,330	1,168,851	1,175,181	0.234249	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,800,616	3,550,798	5,351,414	0.437926	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,757,743	1,018,768	2,776,511	0.263858	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,933,462	3,532,299	5,465,761	0.534090	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	671	281,792	282,463	0.442313	0.000000	90.00
91.00	09100	EMERGENCY	1,565,206	7,681,979	9,247,185	0.281249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,408,120	1,408,120	0.446771	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,747,624	4,747,624	0.580515	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	1,277,596	1,277,596			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	35,613	554,132	589,745			116.00
200.00		Subtotal (see instructions)	32,592,833	75,564,389	108,157,222			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,592,833	75,564,389	108,157,222			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.279746		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515542		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235308		54.00
60.00	06000	LABORATORY	0.225640		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.342011		65.00
66.00	06600	PHYSICAL THERAPY	0.489396		66.00
66.01	06601	CARDIAC REHAB	1.000977		66.01
69.00	06900	ELECTROCARDIOLOGY	0.147498		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.234249		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.437926		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263858		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534090		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.442313		90.00
91.00	09100	EMERGENCY	0.281249		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.446771		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.580515		95.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,605,226		4,605,226	0	4,605,226	30.00
31.00	03100	INTENSIVE CARE UNIT	1,947,030		1,947,030	0	1,947,030	31.00
43.00	04300	NURSERY	485,474		485,474	0	485,474	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,220,627		4,220,627	0	4,220,627	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,093,334		1,093,334	0	1,093,334	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,287,077		4,287,077	0	4,287,077	54.00
60.00	06000	LABORATORY	4,466,835		4,466,835	0	4,466,835	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	696,612	0	696,612	0	696,612	65.00
66.00	06600	PHYSICAL THERAPY	1,642,034	0	1,642,034	0	1,642,034	66.00
66.01	06601	CARDIAC REHAB	381,070	0	381,070	0	381,070	66.01
69.00	06900	ELECTROCARDIOLOGY	120,495		120,495	0	120,495	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	275,285		275,285	0	275,285	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,343,521		2,343,521	0	2,343,521	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	732,606		732,606	0	732,606	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,919,210		2,919,210	0	2,919,210	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	124,937		124,937	0	124,937	90.00
91.00	09100	EMERGENCY	2,600,763		2,600,763	0	2,600,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	629,107		629,107		629,107	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,756,069		2,756,069	0	2,756,069	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,798,297		1,798,297		1,798,297	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	366,087		366,087		366,087	116.00
200.00		Subtotal (see instructions)	38,491,696	0	38,491,696	0	38,491,696	200.00
201.00		Less Observation Beds	629,107		629,107		629,107	201.00
202.00		Total (see instructions)	37,862,589	0	37,862,589	0	37,862,589	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,111,676		9,111,676			30.00
31.00	03100	INTENSIVE CARE UNIT	3,886,417		3,886,417			31.00
43.00	04300	NURSERY	1,024,522		1,024,522			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,998,195	12,089,165	15,087,360	0.279746	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,109,626	11,121	2,120,747	0.515542	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,391,810	16,827,159	18,218,969	0.235308	0.000000	54.00
60.00	06000	LABORATORY	2,714,099	17,082,167	19,796,266	0.225640	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,578,512	458,300	2,036,812	0.342011	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	512,754	2,842,474	3,355,228	0.489396	0.000000	66.00
66.01	06601	CARDIAC REHAB	4,177	376,521	380,698	1.000977	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	161,404	655,523	816,927	0.147498	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,330	1,168,851	1,175,181	0.234249	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,800,616	3,550,798	5,351,414	0.437926	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,757,743	1,018,768	2,776,511	0.263858	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,933,462	3,532,299	5,465,761	0.534090	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	671	281,792	282,463	0.442313	0.000000	90.00
91.00	09100	EMERGENCY	1,565,206	7,681,979	9,247,185	0.281249	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,408,120	1,408,120	0.446771	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	4,747,624	4,747,624	0.580515	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	1,277,596	1,277,596			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	35,613	554,132	589,745			116.00
200.00		Subtotal (see instructions)	32,592,833	75,564,389	108,157,222			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,592,833	75,564,389	108,157,222			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/25/2015 12:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	CARDIAC REHAB	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part I Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	566,042	0	566,042	5,234	108.15	30.00
31.00	INTENSIVE CARE UNIT	229,748		229,748	1,286	178.65	31.00
43.00	NURSERY	68,052		68,052	996	68.33	43.00
200.00	Total (lines 30-199)	863,842		863,842	7,516		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	1,535	166,010				30.00
31.00	INTENSIVE CARE UNIT	474	84,680				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	2,009	250,690				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	738,716	15,087,360	0.048963	647,078	31,683	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	198,464	2,120,747	0.093582	1,861	174	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,286	18,218,969	0.023014	913,651	21,027	54.00
60.00	06000	LABORATORY	258,905	19,796,266	0.013078	1,291,104	16,885	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	50,854	2,036,812	0.024967	751,803	18,770	65.00
66.00	06600	PHYSICAL THERAPY	214,904	3,355,228	0.064050	166,247	10,648	66.00
66.01	06601	CARDIAC REHAB	105,884	380,698	0.278131	744	207	66.01
69.00	06900	ELECTROCARDIOLOGY	2,704	816,927	0.003310	70,392	233	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,336	1,175,181	0.003690	4,583	17	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	74,242	5,351,414	0.013873	562,349	7,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,135	2,776,511	0.002930	678,094	1,987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,321	5,465,761	0.013963	763,563	10,662	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,720	282,463	0.009630	0	0	90.00
91.00	09100	EMERGENCY	337,087	9,247,185	0.036453	604,953	22,052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	77,325	1,408,120	0.054914	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,569,883	87,519,642		6,456,422	142,146	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part III Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,234	0.00	1,535	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,286	0.00	474	0		31.00
43.00	04300	NURSERY	996	0.00	0	0		43.00
200.00		Total (lines 30-199)	7,516		2,009	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,087,360	0.000000	0.000000	647,078	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,120,747	0.000000	0.000000	1,861	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,218,969	0.000000	0.000000	913,651	54.00
60.00	06000	LABORATORY	0	19,796,266	0.000000	0.000000	1,291,104	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	2,036,812	0.000000	0.000000	751,803	65.00
66.00	06600	PHYSICAL THERAPY	0	3,355,228	0.000000	0.000000	166,247	66.00
66.01	06601	CARDIAC REHAB	0	380,698	0.000000	0.000000	744	66.01
69.00	06900	ELECTROCARDIOLOGY	0	816,927	0.000000	0.000000	70,392	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,175,181	0.000000	0.000000	4,583	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	5,351,414	0.000000	0.000000	562,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,776,511	0.000000	0.000000	678,094	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,465,761	0.000000	0.000000	763,563	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	282,463	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	9,247,185	0.000000	0.000000	604,953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	1,408,120	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	87,519,642			6,456,422	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,144,259	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,262,962	0		54.00
60.00	06000	LABORATORY	0	1,158,590	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	101,401	0		65.00
66.00	06600	PHYSICAL THERAPY	0	762	0		66.00
66.01	06601	CARDIAC REHAB	0	143,846	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	163,797	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	264,521	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	393,598	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	197,193	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,109,349	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	67,588	0		90.00
91.00	09100	EMERGENCY	0	1,309,587	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	324,765	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	10,642,218	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.279746	2,144,259	0	0	599,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515542	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235308	3,262,962	0	0	767,801	54.00
60.00	06000	LABORATORY	0.225640	1,158,590	0	0	261,424	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.342011	101,401	0	0	34,680	65.00
66.00	06600	PHYSICAL THERAPY	0.489396	762	0	0	373	66.00
66.01	06601	CARDIAC REHAB	1.000977	143,846	0	0	143,987	66.01
69.00	06900	ELECTROCARDIOLOGY	0.147498	163,797	0	0	24,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.234249	264,521	0	0	61,964	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.437926	393,598	0	0	172,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263858	197,193	0	0	52,031	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534090	1,109,349	0	11,434	592,492	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.442313	67,588	0	0	29,895	90.00
91.00	09100	EMERGENCY	0.281249	1,309,587	0	0	368,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.446771	324,765	0	0	145,096	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.580515		0			95.00
200.00		Subtotal (see instructions)		10,642,218	0	11,434	3,254,438	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		10,642,218	0	11,434	3,254,438	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	CARDIAC REHAB	0	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,107		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	6,107		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	6,107		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,234	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,234	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)	4,519	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,535	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,605,226	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,605,226	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,605,226	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	879.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,350,600	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,350,600	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,947,030	1,286	1,514.02	474	717,645	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)	2,042,119	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,110,364	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)	250,690	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	142,146	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	392,836	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,717,528	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/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)	715	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	879.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	629,107	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	566,042	4,605,226	0.122913	629,107	77,325	90.00
91.00	Nursing School cost	0	4,605,226	0.000000	629,107	0	91.00
92.00	Allied health cost	0	4,605,226	0.000000	629,107	0	92.00
93.00	All other Medical Education	0	4,605,226	0.000000	629,107	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 12:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,234	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,234	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)	4,519	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	450	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)	996	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,605,226	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,605,226	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,605,226	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	879.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	395,942	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)	395,942	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 12:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	485,474	996	487.42	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,947,030	1,286	1,514.02	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	459,822	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	855,764	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)	0	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)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	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/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)	715	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	879.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	629,107	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/25/2015 12:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	566,042	4,605,226	0.122913	629,107	77,325	90.00
91.00	Nursing School cost	0	4,605,226	0.000000	629,107	0	91.00
92.00	Allied health cost	0	4,605,226	0.000000	629,107	0	92.00
93.00	All other Medical Education	0	4,605,226	0.000000	629,107	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,057,970		30.00
31.00	03100	INTENSIVE CARE UNIT		1,485,785		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.279746	647,078	181,017	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515542	1,861	959	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235308	913,651	214,989	54.00
60.00	06000	LABORATORY	0.225640	1,291,104	291,325	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.342011	751,803	257,125	65.00
66.00	06600	PHYSICAL THERAPY	0.489396	166,247	81,361	66.00
66.01	06601	CARDIAC REHAB	1.000977	744	745	66.01
69.00	06900	ELECTROCARDIOLOGY	0.147498	70,392	10,383	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.234249	4,583	1,074	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.437926	562,349	246,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263858	678,094	178,921	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534090	763,563	407,811	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.442313	0	0	90.00
91.00	09100	EMERGENCY	0.281249	604,953	170,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.446771	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		6,456,422	2,042,119	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)		6,456,422		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/25/2015 12:25 pm

Title XIX | Hospital | Cost

		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		520,508		30.00
31.00	03100	INTENSIVE CARE UNIT		197,016		31.00
43.00	04300	NURSERY		232,552		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.279746	236,745	66,228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515542	376,924	194,320	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.235308	48,017	11,299	54.00
60.00	06000	LABORATORY	0.225640	178,796	40,344	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.342011	101,392	34,677	65.00
66.00	06600	PHYSICAL THERAPY	0.489396	36,390	17,809	66.00
66.01	06601	CARDIAC REHAB	1.000977	643	644	66.01
69.00	06900	ELECTROCARDIOLOGY	0.147498	3,881	572	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.234249	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.437926	38,904	17,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.263858	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.534090	116,533	62,239	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.442313	14	6	90.00
91.00	09100	EMERGENCY	0.281249	52,077	14,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.446771	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,190,316	459,822	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,190,316		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E Part A Date/Time Prepared: 2/25/2015 12:25 pm

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		2,830,588			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		0			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		0			1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0			1.03
2.00	Outlier payments for discharges. (see instructions)		5,654			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)		45.04			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 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	Adjusment 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
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.74			30.00
31.00	Percentage of Medicaid patient days (see instructions)		23.25			31.00
32.00	Sum of lines 30 and 31		26.99			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E Part A Date/Time Prepared: 2/25/2015 12:25 pm

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
33.00	Allowable disproportionate share percentage (see instructions)		11.48			33.00
34.00	Disproportionate share adjustment (see instructions)		81,238			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		9,046,380,143	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000048971	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		443,010	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		443,010	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		443,010			36.00
	Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		3,360,490			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0			48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		3,360,490			49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		224,044			50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,584,534			59.00
60.00	Primary payer payments		7,157			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,577,377			61.00
62.00	Deductibles billed to program beneficiaries		479,648			62.00
63.00	Coinsurance billed to program beneficiaries		15,008			63.00
64.00	Allowable bad debts (see instructions)		26,036			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		16,923			65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150045	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 2/25/2015 12:25 pm
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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,890			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,099,644			67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.92	Bundled Model 1 discount amount		0			70.92
70.93	HVBP incentive payment (see instructions)		1,516			70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2014	500,555			70.97
70.98	Low Volume Payment-3		0			70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,601,715			71.00
71.01	Sequestration adjustment (see instructions)		72,034			71.01
72.00	Interim payments		3,539,331			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		-9,650			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0			90.00
91.00	Capital outlier from Worksheet L, Part 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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/25/2015 12:25 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	2,830,588	0	0	2,830,588	2,830,588	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	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, 2013	1.02	0	0	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	5,654	0	0	5,654	5,654	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1148	0.1148	0.1148	0.1148		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	81,238	0	0	81,238	81,238	11.00
11.01	Uncompensated care payments	36.00	443,010	0	0	443,010	443,010	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,360,490	0	0	3,360,490	3,360,490	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	3,360,490	0	0	3,360,490	3,360,490	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	224,044	0	0	224,044	224,044	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	3,584,534	3,584,534	19.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		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	222,858	0	0	222,858	222,858	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	1,186	0	0	1,186	1,186	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 (line 20 times line 22)	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 (line 20 times line 24)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	224,044	0	0	224,044	224,044	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	0.139643		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				500,555	500,555	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150045	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/25/2015 12:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,107	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,254,438	2.00
3.00	PPS payments	2,426,374	3.00
4.00	Outlier payment (see instructions)	1,581	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 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)	6,107	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	11,434	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	11,434	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	11,434	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	5,327	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)	6,107	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	2,427,955	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	587,529	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,846,533	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,846,533	30.00
31.00	Primary payer payments	453	31.00
32.00	Subtotal (line 30 minus line 31)	1,846,080	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	109,226	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	70,997	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	90,179	36.00
37.00	Subtotal (see instructions)	1,917,077	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-18	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
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)	1,917,095	40.00
40.01	Sequestration adjustment (see instructions)	38,342	40.01
41.00	Interim payments	1,807,568	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	71,185	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2015 12:25 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,539,331		1,807,568	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)		3,539,331		1,807,568	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		71,185	6.01
6.02	SETTLEMENT TO PROGRAM		9,650		0	6.02
7.00	Total Medicare program liability (see instructions)		3,529,681		1,878,753	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: 150045	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/25/2015 12:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	2,050	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	2,009	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	867	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	5,805	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	108,157,222	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	1,144,158	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	545,813	8.00
9.00	Sequestration adjustment amount (see instructions)	10,916	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	534,897	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	570,453	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)	-35,556	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150045	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 2/25/2015 12:25 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	855,764		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	855,764	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	855,764	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	950,076		8.00
9.00	Ancillary service charges	1,190,316	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,140,392	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,140,392	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,284,628	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	855,764	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	855,764	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	855,764	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	855,764	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	855,764	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	855,764	0	40.00
41.00	Interim payments	1,224,766	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-369,002	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/25/2015 12:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	14,681	0	0	0	1.00
2.00	Temporary investments	2,937,242	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,471,262	0	0	0	4.00
5.00	Other receivable	756,482	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,494,063	0	0	0	6.00
7.00	Inventory	1,490,596	0	0	0	7.00
8.00	Prepaid expenses	472,764	0	0	0	8.00
9.00	Other current assets	183,905	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)	13,832,869	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	393,118	0	0	0	12.00
13.00	Land improvements	1,692,300	0	0	0	13.00
14.00	Accumulated depreciation	-1,352,381	0	0	0	14.00
15.00	Buildings	52,729,558	0	0	0	15.00
16.00	Accumulated depreciation	-25,147,402	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-1,056,557	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	-173,815	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	23,670,356	0	0	0	23.00
24.00	Accumulated depreciation	-13,411,552	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	-87,018	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	37,256,607	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	18,811,389	0	0	0	31.00
32.00	Deposits on leases	92,809	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,904,198	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	69,993,674	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,731,655	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,894,846	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,073,657	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	751,974	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,452,132	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,166,873	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	11,166,873	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	20,619,005	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	49,374,669				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)	49,374,669	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	69,993,674	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/25/2015 12:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		51,139,272		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,808,642				2.00
3.00	Total (sum of line 1 and line 2)		48,330,630		0		3.00
4.00	NET ASSESTS RELEASED FROM RESTRICTIO	25,000		0		0	4.00
5.00	CONTRIBUTIONS RECEIVED	1,057,216		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,082,216		0		10.00
11.00	Subtotal (line 3 plus line 10)		49,412,846		0		11.00
12.00	NET ASSESTS RELEASED FROM RESTRICTIO	38,177		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		38,177		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,374,669		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	NET ASSESTS RELEASED FROM RESTRICTIO		0		4.00
5.00	CONTRIBUTIONS RECEIVED		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	NET ASSESTS RELEASED FROM RESTRICTIO		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2015 12:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,136,199		10,136,199	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)	10,136,199		10,136,199	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,886,417		3,886,417	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)	3,886,417		3,886,417	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,022,616		14,022,616	17.00
18.00	Ancillary services	16,968,728	59,613,147	76,581,875	18.00
19.00	Outpatient services	1,565,877	9,371,891	10,937,768	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,277,596	1,277,596	22.00
23.00	AMBULANCE SERVICES	0	4,747,624	4,747,624	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	35,613	554,132	589,745	26.00
27.00	DIETARY	0	20,016	20,016	27.00
27.01	DHMG PHYSICIANS	0	9,797,824	9,797,824	27.01
27.02	SELF-INSURANCE	258,790	1,195,631	1,454,421	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	32,851,624	86,577,861	119,429,485	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		60,921,854		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)		60,921,854		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-3 | Date/Time Prepared: 2/25/2015 12:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	119,429,485	1.00
2.00	Less contractual allowances and discounts on patients' accounts	68,509,943	2.00
3.00	Net patient revenues (line 1 minus line 2)	50,919,542	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,921,854	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,002,312	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,340,517	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	5,853,153	24.00
25.00	Total other income (sum of lines 6-24)	7,193,670	25.00
26.00	Total (line 5 plus line 25)	-2,808,642	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,808,642	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H | Date/Time Prepared: 2/25/2015 12:25 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	354,614	186,373	65,478	0	106,810	713,275	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	273,271	0	0	0	0	273,271	6.00
7.00	Physical Therapy	123,490	0	0	0	0	123,490	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	3,855	0	0	0	0	3,855	9.00
10.00	Medical Social Services	27,492	0	0	0	0	27,492	10.00
11.00	Home Health Aide	111,568	0	0	0	0	111,568	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	894,290	186,373	65,478	0	106,810	1,252,951	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-2,737	710,538	-52,159	658,379			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	273,271	0	273,271			6.00
7.00	Physical Therapy	0	123,490	0	123,490			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	3,855	0	3,855			9.00
10.00	Medical Social Services	0	27,492	0	27,492			10.00
11.00	Home Health Aide	0	111,568	0	111,568			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-2,737	1,250,214	-52,159	1,198,055			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 150045 HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-1 Part I Date/Time Prepared: 2/25/2015 12:25 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	658,379	0	0	0	0	658,379	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	273,271	0	0	0	0	273,271	6.00
7.00	Physical Therapy	123,490	0	0	0	0	123,490	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	3,855	0	0	0	0	3,855	9.00
10.00	Medical Social Services	27,492	0	0	0	0	27,492	10.00
11.00	Home Health Aide	111,568	0	0	0	0	111,568	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,198,055	0	0	0	0	1,198,055	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	658,379			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	333,377	606,648		6.00
7.00	Physical Therapy	150,652	274,142		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	4,703	8,558		9.00
10.00	Medical Social Services	33,539	61,031		10.00
11.00	Home Health Aide	136,108	247,676		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
24.00	Total (sum of lines 1-23)		1,198,055		24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150045 HHA CCN: 157157

Period: From 10/01/2013 To 09/30/2014

Worksheet H-1 Part II Date/Time Prepared: 2/25/2015 12:25 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-658,379	539,676	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	273,271	6.00
7.00	Physical Therapy	0	0	0	0	0	123,490	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	3,855	9.00
10.00	Medical Social Services	0	0	0	0	0	27,492	10.00
11.00	Home Health Aide	0	0	0	0	0	111,568	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-658,379	539,676	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		658,379	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.219952	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150045 HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I Date/Time Prepared: 2/25/2015 12:25 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	BUTLER - NEW	
		0	1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	0	3,579	0	0	1.00
2.00	Skilled Nursing Care	606,648	0	0	0	0	0	2.00
3.00	Physical Therapy	274,142	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	8,558	0	0	0	0	0	5.00
6.00	Medical Social Services	61,031	0	0	0	0	0	6.00
7.00	Home Health Aide	247,676	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,198,055	0	0	3,579	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CAPITAL RELATED COSTS MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		1.05	1.06	1.07	1.08	2.00	4.00	
1.00	Administrative and General	0	0	0	0	0	80,600	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	80,600	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I | Date/Time Prepared: 2/25/2015 12:25 pm

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	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4A	5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	84,179	14,422	84,220	0	24,689	0	1.00
2.00	Skilled Nursing Care	606,648	103,932	0	0	0	0	2.00
3.00	Physical Therapy	274,142	46,967	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	8,558	1,466	0	0	0	0	5.00
6.00	Medical Social Services	61,031	10,456	0	0	0	0	6.00
7.00	Home Health Aide	247,676	42,433	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,282,234	219,676	84,220	0	24,689	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000						21.00

	Cost Center Description	SNACK BAR	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.01	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	41,555	145,923	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	41,555	145,923	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150045 HHA CCN: 157157

Period: From 10/01/2013 To 09/30/2014

Worksheet H-2 Part I Date/Time Prepared: 2/25/2015 12:25 pm

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	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		17.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	394,988	0	394,988			1.00
2.00	Skilled Nursing Care	0	710,580	0	710,580	200,007	910,587	2.00
3.00	Physical Therapy	0	321,109	0	321,109	90,382	411,491	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	10,024	0	10,024	2,821	12,845	5.00
6.00	Medical Social Services	0	71,487	0	71,487	20,121	91,608	6.00
7.00	Home Health Aide	0	290,109	0	290,109	81,657	371,766	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	1,798,297	0	1,798,297	394,988	1,798,297	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.281469		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045 HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part II Date/Time Prepared: 2/25/2015 12:25 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)	BUTLER - NEW (SQUARE FEET)	MAC EAST - NEW (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	1.05	
1.00	Administrative and General	0	0	2,772	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	2,772	0	0	0	20.00
21.00	Total cost to be allocated	0	0	3,579	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	1.291126	0.000000	0.000000	0.000000	22.00

	Cost Center Description	CAPITAL RELATED COSTS GARRETT LAB - NEW (SQUARE FEET)	MEDICAL ARTS - NEW (SQUARE FEET)	DAY SPRING - NEW (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	
		1.06	1.07	1.08	2.00	4.00	5A	
1.00	Administrative and General	0	0	0	0	877,480	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	877,480		20.00
21.00	Total cost to be allocated	0	0	0	0	80,600		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.091854		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045 HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part II Date/Time Prepared: 2/25/2015 12:25 pm

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	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	10.01	
1.00	Administrative and General	84,179	2,772	0	2,772	0	0	1.00
2.00	Skilled Nursing Care	606,648	0	0	0	0	0	2.00
3.00	Physical Therapy	274,142	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	8,558	0	0	0	0	0	5.00
6.00	Medical Social Services	61,031	0	0	0	0	0	6.00
7.00	Home Health Aide	247,676	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,282,234	2,772	0	2,772	0	0	20.00
21.00	Total cost to be allocated	219,676	84,220	0	24,689	0	0	21.00
22.00	Unit cost multiplier	0.171323	30.382395	0.000000	8.906566	0.000000	0.000000	22.00

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	1,838	38,228	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,838	38,228	0	0	0	0	20.00
21.00	Total cost to be allocated	41,555	145,923	0	0	0	0	21.00
22.00	Unit cost multiplier	22.608814	3.817176	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150045 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part I | Date/Time Prepared: 2/25/2015 12:25 pm

HHA CCN: 157157 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	910,587		910,587	5,011	181.72	1.00
2.00	Physical Therapy	3.00	411,491	0	411,491	2,063	199.46	2.00
3.00	Occupational Therapy	4.00	0	0	0	0	0.00	3.00
4.00	Speech Pathology	5.00	12,845	0	12,845	96	133.80	4.00
5.00	Medical Social Services	6.00	91,608		91,608	50	1,832.16	5.00
6.00	Home Health Aide	7.00	371,766		371,766	1,886	197.12	6.00
7.00	Total (sum of lines 1-6)		1,798,297	0	1,798,297	9,106		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	198	2,478			8.00
9.00	Physical Therapy		99915	66	898			9.00
10.00	Occupational Therapy		99915	0	0			10.00
11.00	Speech Pathology		99915	1	61			11.00
12.00	Medical Social Services		99915	2	25			12.00
13.00	Home Health Aide		99915	48	1,058			13.00
14.00	Total (sum of lines 8-13)			315	4,520			14.00

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

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	198	2,478		35,981	450,302		1.00
2.00	Physical Therapy	66	898		13,164	179,115		2.00
3.00	Occupational Therapy	0	0		0	0		3.00
4.00	Speech Pathology	1	61		134	8,162		4.00
5.00	Medical Social Services	2	25		3,664	45,804		5.00
6.00	Home Health Aide	48	1,058		9,462	208,553		6.00
7.00	Total (sum of lines 1-6)	315	4,520		62,405	891,936		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150045 HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part I Date/Time Prepared: 2/25/2015 12:25 pm

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	486,283						1.00
2.00	Physical Therapy	192,279						2.00
3.00	Occupational Therapy	0						3.00
4.00	Speech Pathology	8,296						4.00
5.00	Medical Social Services	49,468						5.00
6.00	Home Health Aide	218,015						6.00
7.00	Total (sum of lines 1-6)	954,341						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150045 HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part II Date/Time Prepared: 2/25/2015 12:25 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.489396	0	0	col. 2, line 2.00		1.00
1.01	Physical Therapy 1	66.01	1.000977	0	0	col. 2, line 2.01		1.01
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.437926	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.534090	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/25/2015 12:25 pm

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	37,739	456,047	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	22,530	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	8,738	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,270	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,323	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	366	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	37,739	497,274	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	37,739	497,274	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	37,739	497,274	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	37,739	497,274	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	37,739	497,274	31.00
31.01	Sequestration adjustment (see instructions)	755	9,946	31.01
32.00	Interim payments (see instructions)	36,984	487,329	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 150045 HHA CCN: 157157 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-5 | Date/Time Prepared: 2/25/2015 12:25 pm

Home Health Agency I | 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		36,984		487,329	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		36,984		487,329	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		36,984		487,328	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150045 Hospice CCN: 151559 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K | Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	2,346	0	13,121	68,856	79,845	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	2,217	0	0	0	0	9.00
10.00	Nursing Care	83,486	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	360	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	2,189	0	0	0	0	15.00
16.00	Spiritual Counseling	2,777	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	17,854	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	111,229	0	13,121	68,856	79,845	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150045 Hospice CCN: 151559 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K | Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	164,168	-568	163,600	-81	163,519	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	2,217	0	2,217	0	2,217	9.00
10.00	Nursing Care	83,486	0	83,486	0	83,486	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	360	0	360	0	360	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	2,189	0	2,189	0	2,189	15.00
16.00	Spiritual Counseling	2,777	0	2,777	0	2,777	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	17,854	0	17,854	0	17,854	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	273,051	-568	272,483	-81	272,402	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150045 Hospice CCN: 151559

Period: From 10/01/2013 To 09/30/2014

Worksheet K-1

Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	2,346	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	83,486	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	2,189	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,346	0	2,189	0	83,486	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150045 Hospice CCN: 151559

Period: From 10/01/2013 To 09/30/2014

Worksheet K-1

Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	2,346		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	2,217	2,217		9.00
10.00	Nursing Care		0	0	83,486		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	360	0	0	360		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	2,189		15.00
16.00	Spiritual Counseling		0	2,777	2,777		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		17,854	0	17,854		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	360	17,854	4,994	111,229		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 150045 Hospice CCN: 151559 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K-3 Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 150045 Hospice CCN: 151559 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K-3 Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	68,856	68,856		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	68,856	68,856		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150045 Hospice CCN: 151559

Period: From 10/01/2013 To 09/30/2014

Worksheet K-4 Part I Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	163,519	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	2,217	0	0	0	0	9.00
10.00	Nursing Care	83,486	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	360	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	2,189	0	0	0	0	15.00
16.00	Spiritual Counseling	2,777	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	17,854	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	272,402	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-4
Part I
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	163,519	163,519			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	2,217	3,329	5,546		9.00
10.00	Nursing Care	0	83,486	125,379	208,865		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	360	541	901		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	2,189	3,287	5,476		15.00
16.00	Spiritual Counseling	0	2,777	4,170	6,947		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	17,854	26,813	44,667		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	272,402		272,402		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 Hospice CCN: 151559 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K-4 Part II Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 Hospice CCN: 151559 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K-4 Part II Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-163,519	108,883		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	2,217		9.00
10.00	Nursing Care	0	83,486		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	360		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	2,189		15.00
16.00	Spiritual Counseling	0	2,777		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	17,854		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		163,519		39.00
40.00	Unit Cost Multiplier		1.501786		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part I
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
			BLDG & FIXT	MAC WEST - NEW	NORTH ANNEX - NEW	GARRETT CLINIC - NEW	
		0	1.00	1.01	1.02	1.03	
1.00	Administrative and General		0	0	387	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	5,546	0	0	0	0	4.00
5.00	Nursing Care	208,865	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	901	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	5,476	0	0	0	0	10.00
11.00	Spiritual Counseling	6,947	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	44,667	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	272,402	0	0	387	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part I
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BUTLER - NEW	MAC EAST - NEW	GARRETT LAB - NEW	MEDICAL ARTS - NEW	DAY SPRING - NEW	
		1.04	1.05	1.06	1.07	1.08	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045 Hospice CCN: 151559

Period: From 10/01/2013 To 09/30/2014

Worksheet K-5 Part I Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		2.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	10,025	10,412	1,784	9,115	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	5,546	950	0	4.00
5.00	Nursing Care	0	0	208,865	35,784	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	901	154	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	5,476	938	0	10.00
11.00	Spiritual Counseling	0	0	6,947	1,190	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	44,667	7,653	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	10,025	282,814	48,453	9,115	34.00
35.00	Unit Cost Multiplier (see instructions)			0.000000			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part I
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	SNACK BAR	CAFETERIA	
		8.00	9.00	10.00	10.01	11.00	
1.00	Administrative and General	136	2,672	0	0	3,753	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	136	2,672	0	0	3,753	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045 Hospice CCN: 151559

Period: From 10/01/2013 To 09/30/2014

Worksheet K-5 Part I Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	13,158	0	0	5,986	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	13,158	0	0	5,986	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part I
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	47,016					1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	6,496	0	6,496	957	7,453	4.00
5.00	Nursing Care	244,649	0	244,649	36,050	280,699	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	1,055	0	1,055	155	1,210	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	6,414	0	6,414	945	7,359	10.00
11.00	Spiritual Counseling	8,137	0	8,137	1,199	9,336	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	52,320	0	52,320	7,710	60,030	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	366,087	0	366,087		366,087	34.00
35.00	Unit Cost Multiplier (see instructions)				0.147353		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MAC WEST - NEW (SQUARE FEET)	NORTH ANNEX - NEW (SQUARE FEET)	GARRETT CLINIC - NEW (SQUARE FEET)	BUTLER - NEW (SQUARE FEET)	
		1.00	1.01	1.02	1.03	1.04	
1.00	Administrative and General	0	0	300	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	300	0	0	34.00
35.00	Total cost to be allocated	0	0	387	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	1.290000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		MAC EAST - NEW (SQUARE FEET)	GARRETT LAB - NEW (SQUARE FEET)	MEDICAL ARTS - NEW (SQUARE FEET)	DAY SPRING - NEW (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	
		1.05	1.06	1.07	1.08	2.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (UNADJUSTED SALARY)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	109,138	0	10,412	300	122	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	5,546	0	0	4.00
5.00	Nursing Care	0	0	208,865	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	901	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	5,476	0	0	10.00
11.00	Spiritual Counseling	0	0	6,947	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	44,667	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	109,138		282,814	300	122	34.00
35.00	Total cost to be allocated	10,025		48,453	9,115	136	35.00
36.00	Unit Cost Multiplier (see instructions)	0.091856		0.171325	30.383333	1.114754	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	SNACK BAR (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRS ING)	
		9.00	10.00	10.01	11.00	13.00	
1.00	Administrative and General	300	0	0	166	3,447	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	300	0	0	166	3,447	34.00
35.00	Total cost to be allocated	2,672	0	0	3,753	13,158	35.00
36.00	Unit Cost Multiplier (see instructions)	8.906667	0.000000	0.000000	22.608434	3.817232	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
1.00	Administrative and General	0	0	598,796	0		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	598,796	0		34.00
35.00	Total cost to be allocated	0	0	5,986	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.009997	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150045
Hospice CCN: 151559

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part III
Date/Time Prepared:
2/25/2015 12:25 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.489396	0	0	1.00
1.01	CARDIAC REHAB	66.01	1.000977	0	0	1.01
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.534090	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.225640	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0.437926	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150045 Hospice CCN: 151559

Period: From 10/01/2013 To 09/30/2014

Worksheet K-6

Date/Time Prepared: 2/25/2015 12:25 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				366,087	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,539	2.00
3.00	Average cost per diem (line 1 divided by line 2)				103.44	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,312				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	342,593				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		73			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		7,551			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	1,176				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	121,645				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			154		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			15,930		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150045	Period: From 10/01/2013 To 09/30/2014	Worksheet L Parts I-III Date/Time Prepared: 2/25/2015 12:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	222,858	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,186	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)	16.23	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)	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 (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	224,044	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00