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 10/01/2014
To 09/30/2015

Worksheet S
Parts I-III
Date/Time Prepared:
2/23/2016 3:12 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/23/2016 Time: 3:12 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 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-81,859	84,215	63,705	-96,285	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	0		0	9.00
200.00	Total	0	-81,859	84,215	63,705	-96,285	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2016 3:08 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)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	322	446	0	28	847	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 3:08 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 is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 3:08 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 Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 3:08 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 3:08 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	337,480	23,113	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Line	Description	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

Line	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

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

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

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

Line	Description	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

Line	Description	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

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

Line	Description	1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

Line	Description	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)	07/01/2015	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 3:08 pm

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2016 3:08 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 Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	12/08/2015	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 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/23/2016 3:08 pm

			Part A		Part B	
		Description	Y/N	Date	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

		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)	12/08/2015		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 10/01/2014 To 09/30/2015	Worksheet S-3 Part I Date/Time Prepared: 2/23/2016 3:08 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	29	10,585	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)		29	10,585	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	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)		37	13,505	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)		37				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 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2016 3:08 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)	1,715	316	4,959			1.00
2.00	HMO and other (see instructions)	1,557	1,255				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)	1,715	316	4,959			7.00
8.00	INTENSIVE CARE UNIT	557	0	1,461			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	950			13.00
14.00	Total (see instructions)	2,272	316	7,370	0.00	456.56	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	2,982	0	6,614	0.00	14.86	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	3,677	0	3,708	0.00	1.71	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	473.13	27.00
28.00	Observation Bed Days		46	926			28.00
29.00	Ambulance Trips	1,340					29.00
30.00	Employee discount days (see instruction)			94			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	72	136			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 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2016 3:08 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	693	79	2,379	1.00
2.00	HMO and other (see instructions)			447	340		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	693	79	2,379	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

		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	26,860,597	0	26,860,597	993,600.00	27.03	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		292,451	0	292,451	1,902.00	153.76	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)		9,044,650	-5,975	9,038,675	282,574.00	31.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		977,091	0	977,091	16,972.00	57.57	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		118,875	0	118,875	1,096.00	108.46	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)		5,409,368	0	5,409,368			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,228,272	0	2,228,272			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		23,198	0	23,198			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	179,355	-124	179,231	5,328.00	33.64	26.00
27.00	Administrative & General	5.00	3,538,246	15,879	3,554,125	137,456.00	25.86	27.00
28.00	Administrative & General under contract (see inst.)		398,597	0	398,597	1,665.00	239.40	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	642,510	-446	642,064	23,448.00	27.38	30.00
31.00	Laundry & Linen Service	8.00	28,366	-20	28,346	2,124.00	13.35	31.00
32.00	Housekeeping	9.00	602,315	-418	601,897	48,430.00	12.43	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	564,711	-335,032	229,679	12,405.00	18.52	34.00
35.00	Dietary under contract (see instructions)		1,073	0	1,073	20.00	53.65	35.00
36.00	Cafeteria	11.00	0	334,640	334,640	22,754.00	14.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	726,989	-504	726,485	20,051.00	36.23	38.00
39.00	Central Services and Supply	14.00	90,825	-63	90,762	6,800.00	13.35	39.00
40.00	Pharmacy	15.00	442,114	-307	441,807	11,137.00	39.67	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2016 3:08 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	495,842	-344	495,498	28,040.00	17.67	41.00
42.00	Social Service	17.00	66,630	-46	66,584	1,908.00	34.90	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 10/01/2014 To 09/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 2/23/2016 3:08 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)		27,260,267	0	27,260,267	995,285.00	27.39	1.00
2.00	Excluded area salaries (see instructions)		9,044,650	-5,975	9,038,675	282,574.00	31.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,215,617	5,975	18,221,592	712,711.00	25.57	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,095,966	0	1,095,966	18,068.00	60.66	4.00
5.00	Subtotal wage-related costs (see inst.)		5,432,566	0	5,432,566	0.00	29.81	5.00
6.00	Total (sum of lines 3 thru 5)		24,744,149	5,975	24,750,124	730,779.00	33.87	6.00
7.00	Total overhead cost (see instructions)		7,777,573	13,215	7,790,788	321,566.00	24.23	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 2/23/2016 3:08 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	528,613	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	4,387	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)	4,837,012	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)	47,865	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)	57,496	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	287,103	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	1,824,597	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	22,403	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	51,362	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,660,838	24.00
	Part B - Other than Core Related Cost		
25.00	UNIFORMS	13,708	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part V Date/Time Prepared: 2/23/2016 3:08 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 10/01/2014 To 09/30/2015	Worksheet S-4 Date/Time Prepared: 2/23/2016 3:08 pm
		Home Health Agency I	PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	168.00	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)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.93	0.00	1.93	4.00
5.00	Other Administrative Personnel		5.01	0.00	5.01	5.00
6.00	Direct Nursing Service		3.27	0.00	3.27	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		1.80	0.00	1.80	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.07	0.00	0.07	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.07	0.00	0.07	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.50	0.00	0.50	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		2.08	0.00	2.08	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.		2			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
20.01			50031			20.01

		Full Episodes Without Outliers	Full Episodes 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	1,503	115	47	52	1,717	21.00
22.00	Skilled Nursing Visit Charges	281,175	21,563	8,802	9,717	321,257	22.00
23.00	Physical Therapy Visits	612	8	5	16	641	23.00
24.00	Physical Therapy Visit Charges	113,345	1,484	928	2,968	118,725	24.00
25.00	Occupational Therapy Visits	17	1	0	0	18	25.00
26.00	Occupational Therapy Visit Charges	3,171	188	0	0	3,359	26.00
27.00	Speech Pathology Visits	19	0	0	0	19	27.00
28.00	Speech Pathology Visit Charges	3,610	0	0	0	3,610	28.00
29.00	Medical Social Service Visits	47	2	0	3	52	29.00
30.00	Medical Social Service Visit Charges	13,379	570	0	855	14,804	30.00
31.00	Home Health Aide Visits	439	60	2	34	535	31.00
32.00	Home Health Aide Visit Charges	48,698	6,675	223	3,783	59,379	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,637	186	54	105	2,982	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)	463,378	30,480	9,953	17,323	521,134	35.00
36.00	Total Number of Episodes (standard/non outlier)	186		22	7	215	36.00
37.00	Total Number of Outlier Episodes		5		0	5	37.00
38.00	Total Non-Routine Medical Supply Charges	15,059	2,178	30	91	17,358	38.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 150045 | Component CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-9 Parts I & II | Date/Time Prepared: 2/23/2016 3:08 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	3,629	0	856	0	0	3,629	2.00
3.00	Inpatient Respite Care	10	0	0	0	0	10	3.00
4.00	General Inpatient Care	37	0	0	0	0	37	4.00
5.00	Total Hospice Days	3,676	0	856	0	0	3,676	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	85	0	0	0	0	85	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet S-10 Date/Time Prepared: 2/23/2016 3:08 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)	0.307008	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,892,209	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	11,642,179	6.00
7.00	Medicaid cost (line 1 times line 6)	3,574,242	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)	682,033	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)	682,033	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	1,149,563	0	1,149,563	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	352,925	0	352,925	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)	352,925	0	352,925	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)	5,403,094	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	132,914	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,270,180	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,617,987	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,970,912	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,652,945	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 3:08 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		4,805,256	4,805,256	0	4,805,256	1.00
1.01	00101	MAC WEST - NEW		24,478	24,478	0	24,478	1.01
1.02	00102	NORTH ANNEX - NEW		4,274	4,274	0	4,274	1.02
1.03	00103	GARRETT CLINIC - NEW		16,587	16,587	0	16,587	1.03
1.04	00104	BUTLER - NEW		11,914	11,914	0	11,914	1.04
1.05	00105	MAC EAST - NEW		151,548	151,548	0	151,548	1.05
1.06	00106	GARRETT LAB - NEW		0	0	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW		54,937	54,937	0	54,937	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	179,355	1,574,481	1,753,836	-124	1,753,712	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,538,246	5,856,302	9,394,548	4,565	9,399,113	5.00
7.00	00700	OPERATION OF PLANT	642,510	1,421,283	2,063,793	-446	2,063,347	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,366	50,526	78,892	-20	78,872	8.00
9.00	00900	HOUSEKEEPING	602,315	392,930	995,245	-418	994,827	9.00
10.00	01000	DIETARY	537,459	533,520	1,070,979	-673,662	397,317	10.00
10.01	01001	SNACK BAR	27,252	36,921	64,173	-19	64,154	10.01
11.00	01100	CAFETERIA	0	0	0	673,289	673,289	11.00
13.00	01300	NURSING ADMINISTRATION	726,989	223,246	950,235	-504	949,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90,825	164,206	255,031	-63	254,968	14.00
15.00	01500	PHARMACY	442,114	0	442,114	-307	441,807	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	495,842	160,351	656,193	-344	655,849	16.00
17.00	01700	SOCIAL SERVICE	66,630	11,452	78,082	-46	78,036	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,547,625	877,732	3,425,357	-879,377	2,545,980	30.00
31.00	03100	INTENSIVE CARE UNIT	930,845	444,376	1,375,221	-646	1,374,575	31.00
43.00	04300	NURSERY	0	1,251	1,251	316,510	317,761	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,657,949	1,739,968	3,397,917	-1,150	3,396,767	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	561,100	561,100	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,590,966	1,430,706	3,021,672	-33,024	2,988,648	54.00
60.00	06000	LABORATORY	1,325,035	1,888,105	3,213,140	-919	3,212,221	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	463,594	150,011	613,605	-322	613,283	65.00
66.00	06600	PHYSICAL THERAPY	342,558	837,212	1,179,770	-48,713	1,131,057	66.00
66.01	06601	CARDIAC REHAB	97,295	22,421	119,716	48,408	168,124	66.01
69.00	06900	ELECTROCARDIOLOGY	70,852	5,687	76,539	31,872	108,411	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,109	26,846	72,955	-32	72,923	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,706,314	1,706,314	0	1,706,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	999,275	999,275	0	999,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,270,191	2,270,191	0	2,270,191	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,314	9,347	71,661	-43	71,618	90.00
91.00	09100	EMERGENCY	1,302,902	473,836	1,776,738	-904	1,775,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,122,923	310,175	1,433,098	-779	1,432,319	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	723,434	372,925	1,096,359	9,707	1,106,066	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	134,331	223,864	358,195	1,012	359,207	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,796,635	29,284,454	49,081,089	4,601	49,085,690	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	37,711	41,631	79,342	-26	79,316	192.00
192.01	19201	DEKALB MEDICAL SERVICES	6,621,681	2,902,096	9,523,777	-4,575	9,519,202	192.01
192.02	19202	PHARMACARE	404,570	3,576,349	3,980,919	0	3,980,919	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	396	396	0	396	194.02
200.00		TOTAL (SUM OF LINES 118-199)	26,860,597	35,804,926	62,665,523	0	62,665,523	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 3:08 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	-339,481	4,465,775	1.00
1.01	00101	MAC WEST - NEW	0	24,478	1.01
1.02	00102	NORTH ANNEX - NEW	0	4,274	1.02
1.03	00103	GARRETT CLINIC - NEW	0	16,587	1.03
1.04	00104	BUTLER - NEW	0	11,914	1.04
1.05	00105	MAC EAST - NEW	0	151,548	1.05
1.06	00106	GARRETT LAB - NEW	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW	0	54,937	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	-674,261	1,079,451	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,712,668	7,686,445	5.00
7.00	00700	OPERATION OF PLANT	-9,725	2,053,622	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,736	77,136	8.00
9.00	00900	HOUSEKEEPING	-2,131	992,696	9.00
10.00	01000	DIETARY	-7,102	390,215	10.00
10.01	01001	SNACK BAR	-58,426	5,728	10.01
11.00	01100	CAFETERIA	-244,362	428,927	11.00
13.00	01300	NURSING ADMINISTRATION	0	949,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	254,968	14.00
15.00	01500	PHARMACY	0	441,807	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,275	654,574	16.00
17.00	01700	SOCIAL SERVICE	0	78,036	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-155,650	2,390,330	30.00
31.00	03100	INTENSIVE CARE UNIT	-61,400	1,313,175	31.00
43.00	04300	NURSERY	0	317,761	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-788,825	2,607,942	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	561,100	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-38,220	2,950,428	54.00
60.00	06000	LABORATORY	-1,800	3,210,421	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	613,283	65.00
66.00	06600	PHYSICAL THERAPY	-12,038	1,119,019	66.00
66.01	06601	CARDIAC REHAB	-15,662	152,462	66.01
69.00	06900	ELECTROCARDIOLOGY	-4,380	104,031	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	72,923	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,706,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	999,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,191	2,267,000	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	71,618	90.00
91.00	09100	EMERGENCY	-140,151	1,635,683	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-51,515	1,380,804	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	-48,395	1,057,671	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-216	358,991	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,372,610	44,713,080	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	79,316	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	9,519,202	192.01
192.02	19202	PHARMACARE	-3,210	3,977,709	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	396	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-4,375,820	58,289,703	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	334,640	338,649	1.00
	0		334,640	338,649	
	C - LABOR DELIVERY NURSERY				
1.00	NURSERY	43.00	209,778	106,732	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	371,888	189,212	2.00
	0		581,666	295,944	
	D - NORTH ANNEX RECLASS				
1.00	HOME HEALTH AGENCY	101.00	0	10,209	1.00
2.00	HOSPICE	116.00	0	1,105	2.00
	0		0	11,314	
	E - REHABILITATION OFFICE RECLASS				
1.00	CARDIAC REHAB	66.01	44,625	3,850	1.00
	0		44,625	3,850	
	F - RADIOLOGY ADMIN RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	13,332	18,589	1.00
	0		13,332	18,589	
	G - BONUS ACCRUAL RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	15,879	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
28.00		0.00	0	0	28.00
	0		15,879	0	
500.00	Grand Total: Increases		990,142	668,346	500.00

RECLASSIFICATIONS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 3:08 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	334,640	338,649	0	1.00
	0		334,640	338,649		
	C - LABOR DELIVERY NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	581,666	295,944	0	1.00
2.00		0.00	0	0	0	2.00
	0		581,666	295,944		
	D - NORTH ANNEX RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,314	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	11,314		
	E - REHABILITATION OFFICE RECLASS					
1.00	PHYSICAL THERAPY	66.00	44,625	3,850	0	1.00
	0		44,625	3,850		
	F - RADIOLOGY ADMIN RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	13,332	18,589	0	1.00
	0		13,332	18,589		
	G - BONUS ACCRUAL RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	124	0	0	1.00
2.00	OPERATION OF PLANT	7.00	446	0	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	20	0	0	3.00
4.00	HOUSEKEEPING	9.00	418	0	0	4.00
5.00	DIETARY	10.00	373	0	0	5.00
6.00	SNACK BAR	10.01	19	0	0	6.00
7.00	NURSING ADMINISTRATION	13.00	504	0	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	63	0	0	8.00
9.00	PHARMACY	15.00	307	0	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	344	0	0	10.00
11.00	SOCIAL SERVICE	17.00	46	0	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	1,767	0	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	646	0	0	13.00
14.00	OPERATING ROOM	50.00	1,150	0	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	1,103	0	0	15.00
16.00	LABORATORY	60.00	919	0	0	16.00
17.00	RESPIRATORY THERAPY	65.00	322	0	0	17.00
18.00	PHYSICAL THERAPY	66.00	238	0	0	18.00
19.00	CARDIAC REHAB	66.01	67	0	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	49	0	0	20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	32	0	0	21.00
22.00	CLINIC	90.00	43	0	0	22.00
23.00	EMERGENCY	91.00	904	0	0	23.00
24.00	AMBULANCE SERVICES	95.00	779	0	0	24.00
25.00	HOME HEALTH AGENCY	101.00	502	0	0	25.00
26.00	HOSPICE	116.00	93	0	0	26.00
27.00	PHYSICIANS PRIVATE OFFICES	192.00	26	0	0	27.00
28.00	DEKALB MEDICAL SERVICES	192.01	4,575	0	0	28.00
	0		15,879	0		
500.00	Grand Total: Decreases		990,142	668,346		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I Date/Time Prepared: 2/23/2016 3:08 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	393,118	0	0	0	0	1.00
2.00	Land Improvements	1,692,300	89,670	0	89,670	0	2.00
3.00	Buildings and Fixtures	52,729,557	7,481,117	0	7,481,117	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	23,763,167	8,384,412	0	8,384,412	7,871,199	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,578,142	15,955,199	0	15,955,199	7,871,199	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	78,578,142	15,955,199	0	15,955,199	7,871,199	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	1,781,970	0	2.00
3.00	Buildings and Fixtures	60,210,674	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	24,276,380	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	86,662,142	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	86,662,142	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2016 3:08 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	4,421,775	0	383,481	0	0	1.00
1.01	MAC WEST - NEW	24,478	0	0	0	0	1.01
1.02	NORTH ANNEX - NEW	4,274	0	0	0	0	1.02
1.03	GARRETT CLINIC - NEW	16,587	0	0	0	0	1.03
1.04	BUTLER - NEW	11,914	0	0	0	0	1.04
1.05	MAC EAST - NEW	151,548	0	0	0	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	54,937	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)	4,685,513	0	383,481	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	4,805,256	1.00
1.01	MAC WEST - NEW	0	24,478	1.01
1.02	NORTH ANNEX - NEW	0	4,274	1.02
1.03	GARRETT CLINIC - NEW	0	16,587	1.03
1.04	BUTLER - NEW	0	11,914	1.04
1.05	MAC EAST - NEW	0	151,548	1.05
1.06	GARRETT LAB - NEW	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	54,937	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	5,068,994	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III | Date/Time Prepared: 2/23/2016 3:08 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	4,421,775	0	1.00
1.01	MAC WEST - NEW	0	0	0	24,478	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	4,274	0	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	16,587	0	1.03
1.04	BUTLER - NEW	0	0	0	11,914	0	1.04
1.05	MAC EAST - NEW	0	0	0	151,548	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	54,937	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	4,685,513	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	44,000	0	0	0	4,465,775	1.00
1.01	MAC WEST - NEW	0	0	0	0	24,478	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0	4,274	1.02
1.03	GARRETT CLINIC - NEW	0	0	0	0	16,587	1.03
1.04	BUTLER - NEW	0	0	0	0	11,914	1.04
1.05	MAC EAST - NEW	0	0	0	0	151,548	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0	54,937	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)	44,000	0	0	0	4,729,513	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 3:08 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)	B	-339,481	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	-1,191,075			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	-1,736	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-244,362	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	-752	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,275	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 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 3:08 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	-3,621	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-116,951	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	INVESTMENT MANAGEMENT FEES	B	34,267	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.05	WASTE DISPOSAL REVENUE	B	-225	OPERATION OF PLANT	7.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-9,500	OPERATION OF PLANT	7.00	0	33.06
33.07	HOUSEKEEPING INCOME	B	-2,131	HOUSEKEEPING	9.00	0	33.07
33.08	RADIOLOGY NON-PATIENT REVENUE	B	-236	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	NON-PATIENT LAB REVENUE	B	-1,800	LABORATORY	60.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	-14,313	CARDIAC REHAB	66.01	0	33.10
33.11	MISCELLANEOUS INCOME	B	-2,439	DRUGS CHARGED TO PATIENTS	73.00	0	33.11
33.12	AMBULANCE SERVICE REVENUE	B	-51,515	AMBULANCE SERVICES	95.00	0	33.12
33.15	DIABETES SERVICE MISC INCOME	B	-7,102	DIETARY	10.00	0	33.15
33.16	HOME HEALTH MISCELLANEOUS INCOME	B	-48,007	HOME HEALTH AGENCY	101.00	0	33.16
33.18	LOBBYING PORTION OF IHA & AHA DUES	A	-4,796	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	LOBBYING PORTION OF IAHHC DUES - HOS	A	-107	HOSPICE	116.00	0	33.19
33.20	LOBBYING PORTION OF IAHHC DUES - HHA	A	-234	HOME HEALTH AGENCY	101.00	0	33.20
33.23	NON-ALLOWABLE MARKETING	A	-993	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	NON-ALLOWABLE MARKETING	A	-405,280	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	NON-ALLOWABLE MARKETING	A	-585	RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26	NON-ALLOWABLE MARKETING	A	-11,506	PHYSICAL THERAPY	66.00	0	33.26
33.27	NON-ALLOWABLE MARKETING	A	-1,349	CARDIAC REHAB	66.01	0	33.27
33.28	NON-ALLOWABLE MARKETING	A	-154	HOME HEALTH AGENCY	101.00	0	33.28
33.31	NON-ALLOWABLE MARKETING	A	-109	HOSPICE	116.00	9	33.31
33.32	NON-ALLOWABLE MARKETING	A	-3,210	PHARMACARE	192.02	0	33.32
33.33	SNACK BAR	A	-58,426	SNACK BAR	10.01	0	33.33
33.37	FLOWER/GIFTS	A	-7,363	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.39	SELF-INSURANCE EXPENSES	A	-669,428	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39
33.40	CHRISTMAS PARTY & OPEN HOUSE	A	-219	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.40
33.41	PHYSICIAN RECRUITMENT	A	-22,714	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	THERAPY MISCELLANEOUS REVENUE	B	-532	PHYSICAL THERAPY	66.00	0	33.42
33.43	HAF FEE	A	-1,186,561	ADMINISTRATIVE & GENERAL	5.00	0	33.43
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,375,820				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

ADJUSTMENTS TO EXPENSES | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 3:08 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	

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2016 3:08 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	54.00	RADIOLOGY-DIAGNOSTIC	37,399	37,399	0	177,200	0	1.00
2.00	50.00	OPERATING ROOM	788,175	788,175	0	177,200	0	2.00
3.00	91.00	EMERGENCY	140,151	140,151	0	177,200	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	16,475	0	16,475	177,200	155	4.00
5.00	69.00	ELECTROCARDIOLOGY	3,080	3,080	0	177,200	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	50,400	50,400	0	177,200	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	148,800	148,800	0	177,200	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	1,300	1,300	0	177,200	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	6,850	6,850	0	177,200	0	9.00
10.00	31.00	INTENSIVE CARE UNIT	11,000	11,000	0	177,200	0	10.00
11.00	50.00	OPERATING ROOM	650	650	0	177,200	0	11.00
200.00			1,204,280	1,187,805	16,475		155	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	13,205	660	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	9.00
10.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	10.00
11.00	50.00	OPERATING ROOM	0	0	0	0	0	11.00
200.00			13,205	660	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	37,399	1.00
2.00	50.00	OPERATING ROOM	0	0	0	788,175	2.00
3.00	91.00	EMERGENCY	0	0	0	140,151	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	0	13,205	3,270	3,270	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	3,080	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	50,400	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	148,800	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,300	8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	6,850	9.00
10.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,000	10.00
11.00	50.00	OPERATING ROOM	0	0	0	650	11.00
200.00			0	13,205	3,270	1,191,075	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 3:08 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	4,465,775	4,465,775				1.00
1.01	00101	MAC WEST - NEW	24,478	0	24,478			1.01
1.02	00102	NORTH ANNEX - NEW	4,274	0	0	4,274		1.02
1.03	00103	GARRETT CLINIC - NEW	16,587	0	0	0	16,587	1.03
1.04	00104	BUTLER - NEW	11,914	0	0	0	0	1.04
1.05	00105	MAC EAST - NEW	151,548	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	54,937	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	1,079,451	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,686,445	560,582	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	2,053,622	1,746,246	4,392	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,136	26,001	0	0	0	8.00
9.00	00900	HOUSEKEEPING	992,696	41,571	0	0	0	9.00
10.00	01000	DIETARY	390,215	21,820	0	0	0	10.00
10.01	01001	SNACK BAR	5,728	0	0	0	0	10.01
11.00	01100	CAFETERIA	428,927	51,326	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	949,731	23,083	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	254,968	27,416	0	0	0	14.00
15.00	01500	PHARMACY	441,807	25,217	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	654,574	60,864	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	78,036	3,571	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,390,330	255,346	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,313,175	108,423	0	0	0	31.00
43.00	04300	NURSERY	317,761	19,424	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,607,942	386,330	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	561,100	300,423	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,950,428	202,844	0	0	0	54.00
60.00	06000	LABORATORY	3,210,421	91,220	995	0	3,468	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	613,283	23,779	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,119,019	113,584	0	0	0	66.00
66.01	06601	CARDIAC REHAB	152,462	59,775	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	104,031	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,923	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,706,314	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	999,275	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,267,000	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,618	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,635,683	167,589	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,380,804	38,261	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,057,671	0	0	2,420	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	358,991	0	0	262	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,713,080	4,354,695	5,387	2,682	3,468	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	79,316	0	5,357	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	9,519,202	111,080	13,734	1,592	13,119	192.01
192.02	19202	PHARMACARE	3,977,709	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	396	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)	58,289,703	4,465,775	24,478	4,274	16,587	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 3:08 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	151,548				1.05
1.06	00106	GARRETT LAB - NEW	0	0	0			1.06
1.07	00107	MEDICAL ARTS - NEW	0	0	0	54,937		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	20,293	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	45,043	0	4,357	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	307	0	0	0	9.00
10.00	01000	DIETARY	0	825	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	1,148	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	67,616	0	4,357	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	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	11,071	83,932	0	50,580	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	151,548	0	54,937	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 3:08 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	1,079,451				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	143,789	8,411,109	8,411,109		5.00
7.00	00700	OPERATION OF PLANT	0	25,976	3,879,636	654,231	4,533,867	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,147	104,284	17,586	34,839	8.00
9.00	00900	HOUSEKEEPING	0	24,351	1,058,925	178,569	57,919	9.00
10.00	01000	DIETARY	0	8,190	421,050	71,003	35,189	10.00
10.01	01001	SNACK BAR	0	1,102	6,830	1,152	0	10.01
11.00	01100	CAFETERIA	0	13,539	493,792	83,269	68,773	11.00
13.00	01300	NURSING ADMINISTRATION	0	29,391	1,002,205	169,004	30,929	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,672	286,056	48,238	36,735	14.00
15.00	01500	PHARMACY	0	17,874	484,898	81,769	33,788	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,046	736,632	124,220	89,839	16.00
17.00	01700	SOCIAL SERVICE	0	2,694	84,301	14,216	4,785	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	79,465	2,725,141	459,546	342,142	30.00
31.00	03100	INTENSIVE CARE UNIT	0	37,633	1,459,231	246,073	145,278	31.00
43.00	04300	NURSERY	0	8,487	345,672	58,291	26,027	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	67,029	3,061,301	516,233	517,649	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,045	876,568	147,817	402,541	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	63,782	3,217,054	542,498	271,794	54.00
60.00	06000	LABORATORY	0	53,570	3,360,517	566,691	174,748	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	18,743	655,805	110,590	31,862	65.00
66.00	06600	PHYSICAL THERAPY	0	12,044	1,244,647	209,887	152,193	66.00
66.01	06601	CARDIAC REHAB	0	5,739	217,976	36,758	80,094	66.01
69.00	06900	ELECTROCARDIOLOGY	0	3,404	107,435	18,117	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,864	74,787	12,611	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,706,314	287,739	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	999,275	168,510	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,267,000	382,289	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,519	74,137	12,502	0	90.00
91.00	09100	EMERGENCY	0	52,675	1,855,947	312,972	224,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	45,399	1,464,464	246,955	51,266	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	29,248	1,089,339	183,697	80,882	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	5,431	364,684	61,497	8,753	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	793,848	44,137,012	6,024,530	2,902,580	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	1,525	86,198	14,536	104,312	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	267,710	10,072,020	1,698,447	1,526,975	192.01
192.02	19202	PHARMACARE	0	16,368	3,994,077	673,529	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	396	67	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	1,079,451	58,289,703	8,411,109	4,533,867	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 3:08 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	156,709					8.00
9.00	00900	HOUSEKEEPING	11,528	1,306,941				9.00
10.00	01000	DIETARY	0	10,355	537,597			10.00
10.01	01001	SNACK BAR	0	0	0	7,982		10.01
11.00	01100	CAFETERIA	0	20,239	0	7,982	674,055	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,102	0	0	19,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,811	0	0	6,824	14.00
15.00	01500	PHARMACY	0	9,943	0	0	11,165	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,438	0	0	28,341	16.00
17.00	01700	SOCIAL SERVICE	0	1,408	0	0	2,066	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,335	100,686	420,128	0	85,650	30.00
31.00	03100	INTENSIVE CARE UNIT	13,873	42,753	117,469	0	34,060	31.00
43.00	04300	NURSERY	0	7,659	0	0	6,950	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,784	152,335	0	0	56,328	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	118,461	0	0	12,313	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,741	79,984	0	0	52,843	54.00
60.00	06000	LABORATORY	0	51,425	0	0	54,032	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	377	9,377	0	0	17,552	65.00
66.00	06600	PHYSICAL THERAPY	0	44,788	0	0	12,981	66.00
66.01	06601	CARDIAC REHAB	0	23,570	0	0	6,386	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	4,299	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	537	0	0	0	1,795	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	855	0	0	0	2,296	90.00
91.00	09100	EMERGENCY	31,032	66,082	0	0	44,474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,080	15,087	0	0	55,034	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	23,802	0	0	31,013	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	94	2,576	0	0	3,569	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	155,236	826,881	537,597	7,982	549,630	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	30,697	0	0	7,743	192.00
192.01	19201	DEKALB MEDICAL SERVICES	1,473	449,363	0	0	116,682	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)	156,709	1,306,941	537,597	7,982	674,055	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 3:08 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	1,230,899					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,906	417,570				14.00
15.00	01500	PHARMACY	0	0	621,563			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,005,470		16.00
17.00	01700	SOCIAL SERVICE	8,740	0	0	0	115,516	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	362,842	0	0	97,403	115,516	30.00
31.00	03100	INTENSIVE CARE UNIT	144,254	0	0	47,100	0	31.00
43.00	04300	NURSERY	29,446	0	0	8,346	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	238,611	0	0	199,972	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52,201	0	0	14,795	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	191,405	0	54.00
60.00	06000	LABORATORY	21,229	0	0	142,683	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	40,970	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	31,567	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	3,884	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,595	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,748	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	417,570	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	621,563	174	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,709	0	0	2,843	0	90.00
91.00	09100	EMERGENCY	188,446	0	0	102,654	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	131,433	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	15,082	0	0	5,687	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,230,899	417,570	621,563	907,826	115,516	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	97,644	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)	1,230,899	417,570	621,563	1,005,470	115,516	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 3:08 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	4,758,389	0	4,758,389		30.00
31.00	03100	INTENSIVE CARE UNIT	2,250,091	0	2,250,091		31.00
43.00	04300	NURSERY	482,391	0	482,391		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	4,766,213	0	4,766,213		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,624,696	0	1,624,696		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,375,319	0	4,375,319		54.00
60.00	06000	LABORATORY	4,371,325	0	4,371,325		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	866,533	0	866,533		65.00
66.00	06600	PHYSICAL THERAPY	1,696,063	0	1,696,063		66.00
66.01	06601	CARDIAC REHAB	368,668	0	368,668		66.01
69.00	06900	ELECTROCARDIOLOGY	140,446	0	140,446		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,478	0	97,478		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,411,623	0	2,411,623		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,167,785	0	1,167,785		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,271,026	0	3,271,026		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	102,342	0	102,342		90.00
91.00	09100	EMERGENCY	2,826,162	0	2,826,162		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,836,886	0	1,836,886		95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	1,540,166	0	1,540,166		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	461,942	0	461,942		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,415,544	0	39,415,544		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	243,486	0	243,486		192.00
192.01	19201	DEKALB MEDICAL SERVICES	13,962,604	0	13,962,604		192.01
192.02	19202	PHARMACARE	4,667,606	0	4,667,606		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	463	0	463		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)	58,289,703	0	58,289,703		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 3:08 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	560,582	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	1,746,246	4,392	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,001	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	41,571	0	0	0	9.00
10.00	01000	DIETARY	0	21,820	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	51,326	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,083	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,416	0	0	0	14.00
15.00	01500	PHARMACY	0	25,217	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,864	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,571	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	255,346	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	108,423	0	0	0	31.00
43.00	04300	NURSERY	0	19,424	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	386,330	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	300,423	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	202,844	0	0	0	54.00
60.00	06000	LABORATORY	0	91,220	995	0	3,468	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	23,779	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	113,584	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	59,775	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	167,589	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	38,261	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	2,420	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	262	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,354,695	5,387	2,682	3,468	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	5,357	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	111,080	13,734	1,592	13,119	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	4,465,775	24,478	4,274	16,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 3:08 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	20,293	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	45,043	0	4,357	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	307	0	0	0	9.00
10.00	01000	DIETARY	0	825	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	1,148	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	67,616	0	4,357	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	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	11,071	83,932	0	50,580	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	151,548	0	54,937	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/23/2016 3:08 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	580,875	0	580,875		5.00
7.00	00700	OPERATION OF PLANT	0	1,800,038	0	45,182	1,845,220	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,001	0	1,214	14,179	8.00
9.00	00900	HOUSEKEEPING	0	41,878	0	12,332	23,572	9.00
10.00	01000	DIETARY	0	22,645	0	4,904	14,321	10.00
10.01	01001	SNACK BAR	0	0	0	80	0	10.01
11.00	01100	CAFETERIA	0	51,326	0	5,751	27,990	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,083	0	11,672	12,588	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,416	0	3,331	14,951	14.00
15.00	01500	PHARMACY	0	25,217	0	5,647	13,751	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	62,012	0	8,579	36,563	16.00
17.00	01700	SOCIAL SERVICE	0	3,571	0	982	1,948	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	255,346	0	31,737	139,247	30.00
31.00	03100	INTENSIVE CARE UNIT	0	108,423	0	16,994	59,126	31.00
43.00	04300	NURSERY	0	19,424	0	4,026	10,593	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	386,330	0	35,652	210,676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	300,423	0	10,209	163,828	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	202,844	0	37,466	110,616	54.00
60.00	06000	LABORATORY	0	96,526	0	39,137	71,120	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	23,779	0	7,638	12,968	65.00
66.00	06600	PHYSICAL THERAPY	0	113,584	0	14,495	61,940	66.00
66.01	06601	CARDIAC REHAB	0	59,775	0	2,539	32,597	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,251	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	871	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	19,872	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,638	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,401	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	863	0	90.00
91.00	09100	EMERGENCY	0	167,589	0	21,614	91,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	38,261	0	17,055	20,865	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	2,420	0	12,686	32,918	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	262	0	4,247	3,563	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,439,048	0	416,065	1,181,311	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	5,357	0	1,004	42,453	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	285,108	0	117,286	621,456	192.01
192.02	19202	PHARMACARE	0	0	0	46,515	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	5	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	4,729,513	0	580,875	1,845,220	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/23/2016 3:08 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	41,394					8.00
9.00	00900	HOUSEKEEPING	3,045	80,827				9.00
10.00	01000	DIETARY	0	640	42,510			10.00
10.01	01001	SNACK BAR	0	0	0	80		10.01
11.00	01100	CAFETERIA	0	1,252	0	80	86,399	11.00
13.00	01300	NURSING ADMINISTRATION	0	563	0	0	2,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	669	0	0	875	14.00
15.00	01500	PHARMACY	0	615	0	0	1,431	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,635	0	0	3,633	16.00
17.00	01700	SOCIAL SERVICE	0	87	0	0	265	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,030	6,227	33,221	0	10,978	30.00
31.00	03100	INTENSIVE CARE UNIT	3,665	2,644	9,289	0	4,366	31.00
43.00	04300	NURSERY	0	474	0	0	891	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,282	9,421	0	0	7,220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,326	0	0	1,578	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,215	4,947	0	0	6,773	54.00
60.00	06000	LABORATORY	0	3,180	0	0	6,926	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	100	580	0	0	2,250	65.00
66.00	06600	PHYSICAL THERAPY	0	2,770	0	0	1,664	66.00
66.01	06601	CARDIAC REHAB	0	1,458	0	0	819	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	551	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	142	0	0	0	230	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	226	0	0	0	294	90.00
91.00	09100	EMERGENCY	8,197	4,087	0	0	5,701	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,078	933	0	0	7,054	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,472	0	0	3,975	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	25	159	0	0	457	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,005	51,139	42,510	80	70,451	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	1,898	0	0	992	192.00
192.01	19201	DEKALB MEDICAL SERVICES	389	27,790	0	0	14,956	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)	41,394	80,827	42,510	80	86,399	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 3:08 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	50,426					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,184	48,426				14.00
15.00	01500	PHARMACY	0	0	46,661			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	112,422		16.00
17.00	01700	SOCIAL SERVICE	358	0	0	0	7,211	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,864	0	0	10,896	7,211	30.00
31.00	03100	INTENSIVE CARE UNIT	5,910	0	0	5,269	0	31.00
43.00	04300	NURSERY	1,206	0	0	934	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,775	0	0	22,316	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,139	0	0	1,655	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,412	0	54.00
60.00	06000	LABORATORY	870	0	0	15,961	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,583	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,531	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	434	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,185	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	867	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	48,426	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	46,661	19	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	398	0	0	318	0	90.00
91.00	09100	EMERGENCY	7,720	0	0	11,483	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	5,384	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	618	0	0	636	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,426	48,426	46,661	101,499	7,211	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	10,923	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	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)	50,426	48,426	46,661	112,422	7,211	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/23/2016 3:08 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	522,757	0	522,757		30.00
31.00	03100	INTENSIVE CARE UNIT	215,686	0	215,686		31.00
43.00	04300	NURSERY	37,548	0	37,548		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	687,672	0	687,672		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	487,158	0	487,158		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	389,273	0	389,273		54.00
60.00	06000	LABORATORY	233,720	0	233,720		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	51,898	0	51,898		65.00
66.00	06600	PHYSICAL THERAPY	197,984	0	197,984		66.00
66.01	06601	CARDIAC REHAB	97,622	0	97,622		66.01
69.00	06900	ELECTROCARDIOLOGY	2,987	0	2,987		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,110	0	2,110		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	68,298	0	68,298		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,638	0	11,638		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,081	0	73,081		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,099	0	2,099		90.00
91.00	09100	EMERGENCY	317,782	0	317,782		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	85,246	0	85,246		95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	58,855	0	58,855		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	9,967	0	9,967		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,553,381	0	3,553,381		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	51,704	0	51,704		192.00
192.01	19201	DEKALB MEDICAL SERVICES	1,077,908	0	1,077,908		192.01
192.02	19202	PHARMACARE	46,515	0	46,515		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	5	0	5		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)	4,729,513	0	4,729,513		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 3:08 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	205,077					1.00
1.01	00101	MAC WEST - NEW	0	16,334				1.01
1.02	00102	NORTH ANNEX - NEW	0	0	4,896			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	892	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	13,796	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	7,696	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,757	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)	199,976	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	0	3,575	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	5,101	9,164	1,824	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)	4,465,775	24,478	4,274	16,587	11,914	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.776089	1.498592	0.872958	4.423200	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 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 3:08 pm

			CAPITAL RELATED COSTS					
		Cost Center Description	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 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 3:08 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					205,077	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	892	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	13,796	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	7,696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	1,757	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	199,976	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	20,758	0	7,895	0	5,101	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)	151,548	0	54,937	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.043329	0.000000	6.406647	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 10/01/2014 To 09/30/2015	Worksheet B-1 Date/Time Prepared: 2/23/2016 3:08 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 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 3:08 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	26,681,366					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,554,125	-8,411,109	49,878,594			5.00
7.00	00700	OPERATION OF PLANT	642,064	0	3,879,636	155,386		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,346	0	104,284	1,194	287,361	8.00
9.00	00900	HOUSEKEEPING	601,897	0	1,058,925	1,985	21,139	9.00
10.00	01000	DIETARY	202,446	0	421,050	1,206	0	10.00
10.01	01001	SNACK BAR	27,233	0	6,830	0	0	10.01
11.00	01100	CAFETERIA	334,640	0	493,792	2,357	0	11.00
13.00	01300	NURSING ADMINISTRATION	726,485	0	1,002,205	1,060	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	90,762	0	286,056	1,259	0	14.00
15.00	01500	PHARMACY	441,807	0	484,898	1,158	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	495,498	0	736,632	3,079	0	16.00
17.00	01700	SOCIAL SERVICE	66,584	0	84,301	164	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,964,192	0	2,725,141	11,726	90,467	30.00
31.00	03100	INTENSIVE CARE UNIT	930,199	0	1,459,231	4,979	25,440	31.00
43.00	04300	NURSERY	209,778	0	345,672	892	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,656,799	0	3,061,301	17,741	43,613	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	371,888	0	876,568	13,796	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,576,531	0	3,217,054	9,315	36,200	54.00
60.00	06000	LABORATORY	1,324,116	0	3,360,517	5,989	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	463,272	0	655,805	1,092	692	65.00
66.00	06600	PHYSICAL THERAPY	297,695	0	1,244,647	5,216	0	66.00
66.01	06601	CARDIAC REHAB	141,853	0	217,976	2,745	0	66.01
69.00	06900	ELECTROCARDIOLOGY	84,135	0	107,435	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,077	0	74,787	0	984	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,706,314	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	999,275	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,267,000	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,271	0	74,137	0	1,568	90.00
91.00	09100	EMERGENCY	1,301,998	0	1,855,947	7,696	56,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,122,144	0	1,464,464	1,757	7,481	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	722,932	0	1,089,339	2,772	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	134,238	0	364,684	300	172	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,622,005	-8,411,109	35,725,903	99,478	284,660	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	37,685	0	86,198	3,575	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	6,617,106	0	10,072,020	52,333	2,701	192.01
192.02	19202	PHARMACARE	404,570	0	3,994,077	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	396	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)	1,079,451		8,411,109	4,533,867	156,709	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.040457		0.168632	29.178092	0.545338	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		580,875	1,845,220	41,394	204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet B-1 Date/Time Prepared: 2/23/2016 3:08 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		0.011646	11.875072	0.144049	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 3:08 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	152,207					9.00
10.00	01000	DIETARY	1,206	27,157				10.00
10.01	01001	SNACK BAR	0	0	1			10.01
11.00	01100	CAFETERIA	2,357	0	1	32,298		11.00
13.00	01300	NURSING ADMINISTRATION	1,060	0	0	942	289,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	0	0	327	6,800	14.00
15.00	01500	PHARMACY	1,158	0	0	535	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,079	0	0	1,358	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	0	99	2,056	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,726	21,223	0	4,104	85,357	30.00
31.00	03100	INTENSIVE CARE UNIT	4,979	5,934	0	1,632	33,935	31.00
43.00	04300	NURSERY	892	0	0	333	6,927	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,741	0	0	2,699	56,132	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,796	0	0	590	12,280	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,315	0	0	2,532	0	54.00
60.00	06000	LABORATORY	5,989	0	0	2,589	4,994	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,092	0	0	841	0	65.00
66.00	06600	PHYSICAL THERAPY	5,216	0	0	622	0	66.00
66.01	06601	CARDIAC REHAB	2,745	0	0	306	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	206	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	86	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	110	2,284	90.00
91.00	09100	EMERGENCY	7,696	0	0	2,131	44,331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,757	0	0	2,637	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,772	0	0	1,486	30,919	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	300	0	0	171	3,548	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,299	27,157	1	26,336	289,563	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	3,575	0	0	371	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	52,333	0	0	5,591	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						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,306,941	537,597	7,982	674,055	1,230,899	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.586602	19.795891	7,982.000000	20.869868	4.250885	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	80,827	42,510	80	86,399	50,426	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 3:08 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)	0.531033	1.565342	80.000000	2.675057	0.174145	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 3:08 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	126,517,564			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	12,256,571	100		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,926,778	0		31.00
43.00	04300	NURSERY	0	0	1,050,185	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	25,158,800	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,861,737	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	24,085,151	0		54.00
60.00	06000	LABORATORY	0	0	17,954,379	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	5,155,423	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,972,181	0		66.00
66.01	06601	CARDIAC REHAB	0	0	488,749	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	1,333,223	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	974,990	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	21,896	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	357,782	0		90.00
91.00	09100	EMERGENCY	0	0	12,917,290	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	715,591	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	114,230,726	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	12,286,838	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)	417,570	621,563	1,005,470	115,516		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4,175.700000	6,215.630000	0.007947	1,155.160000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,426	46,661	112,422	7,211		204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet B-1 Date/Time Prepared: 2/23/2016 3:08 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)	484.260000	466.610000	0.000889	72.110000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	4,758,389		4,758,389	0	4,758,389	30.00
31.00	03100	INTENSIVE CARE UNIT	2,250,091		2,250,091	0	2,250,091	31.00
43.00	04300	NURSERY	482,391		482,391	0	482,391	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,766,213		4,766,213	0	4,766,213	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,624,696		1,624,696	0	1,624,696	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,375,319		4,375,319	0	4,375,319	54.00
60.00	06000	LABORATORY	4,371,325		4,371,325	0	4,371,325	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	866,533	0	866,533	0	866,533	65.00
66.00	06600	PHYSICAL THERAPY	1,696,063	0	1,696,063	0	1,696,063	66.00
66.01	06601	CARDIAC REHAB	368,668	0	368,668	0	368,668	66.01
69.00	06900	ELECTROCARDIOLOGY	140,446		140,446	0	140,446	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,478		97,478	0	97,478	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,411,623		2,411,623	0	2,411,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,167,785		1,167,785	0	1,167,785	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,271,026		3,271,026	0	3,271,026	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	102,342		102,342	0	102,342	90.00
91.00	09100	EMERGENCY	2,826,162		2,826,162	0	2,826,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	748,727		748,727		748,727	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,836,886		1,836,886	0	1,836,886	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,540,166		1,540,166		1,540,166	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	461,942		461,942		461,942	116.00
200.00		Subtotal (see instructions)	40,164,271	0	40,164,271	0	40,164,271	200.00
201.00		Less Observation Beds	748,727		748,727		748,727	201.00
202.00		Total (see instructions)	39,415,544	0	39,415,544	0	39,415,544	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	10,061,482		10,061,482			30.00
31.00	03100	INTENSIVE CARE UNIT	4,425,869		4,425,869			31.00
43.00	04300	NURSERY	1,036,425		1,036,425			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,173,293	13,441,538	16,614,831	0.286865	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,830,612	8,409	1,839,021	0.883457	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,016,192	21,510,994	23,527,186	0.185969	0.000000	54.00
60.00	06000	LABORATORY	3,050,056	17,881,093	20,931,149	0.208843	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,617,449	920,417	4,537,866	0.190956	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	834,136	3,080,909	3,915,045	0.433217	0.000000	66.00
66.01	06601	CARDIAC REHAB	5,867	475,244	481,111	0.766285	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	253,325	1,060,553	1,313,878	0.106894	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	585	959,098	959,683	0.101573	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,716,550	4,153,775	5,870,325	0.410816	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,741,584	1,124,969	3,866,553	0.302022	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,381,554	4,310,677	6,692,231	0.488780	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	170	234,544	234,714	0.436029	0.000000	90.00
91.00	09100	EMERGENCY	2,284,787	10,197,205	12,481,992	0.226419	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,118,399	2,118,399	0.353440	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,757,465	5,757,465	0.319044	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	1,016,253	1,016,253			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	22,097	682,396	704,493			116.00
200.00		Subtotal (see instructions)	39,452,033	88,933,938	128,385,971			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,452,033	88,933,938	128,385,971			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/23/2016 3:08 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	0.286865	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.883457	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185969	54.00
60.00	06000	LABORATORY	0.208843	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.190956	65.00
66.00	06600	PHYSICAL THERAPY	0.433217	66.00
66.01	06601	CARDIAC REHAB	0.766285	66.01
69.00	06900	ELECTROCARDIOLOGY	0.106894	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101573	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.410816	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488780	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.436029	90.00
91.00	09100	EMERGENCY	0.226419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.353440	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.319044	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 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 3:08 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	4,758,389		4,758,389	0	4,758,389	30.00
31.00	03100	INTENSIVE CARE UNIT	2,250,091		2,250,091	0	2,250,091	31.00
43.00	04300	NURSERY	482,391		482,391	0	482,391	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,766,213		4,766,213	0	4,766,213	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,624,696		1,624,696	0	1,624,696	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,375,319		4,375,319	0	4,375,319	54.00
60.00	06000	LABORATORY	4,371,325		4,371,325	0	4,371,325	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	866,533	0	866,533	0	866,533	65.00
66.00	06600	PHYSICAL THERAPY	1,696,063	0	1,696,063	0	1,696,063	66.00
66.01	06601	CARDIAC REHAB	368,668	0	368,668	0	368,668	66.01
69.00	06900	ELECTROCARDIOLOGY	140,446		140,446	0	140,446	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,478		97,478	0	97,478	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,411,623		2,411,623	0	2,411,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,167,785		1,167,785	0	1,167,785	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,271,026		3,271,026	0	3,271,026	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	102,342		102,342	0	102,342	90.00
91.00	09100	EMERGENCY	2,826,162		2,826,162	0	2,826,162	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	748,727		748,727		748,727	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,836,886		1,836,886	0	1,836,886	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,540,166		1,540,166		1,540,166	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	461,942		461,942		461,942	116.00
200.00		Subtotal (see instructions)	40,164,271	0	40,164,271	0	40,164,271	200.00
201.00		Less Observation Beds	748,727		748,727		748,727	201.00
202.00		Total (see instructions)	39,415,544	0	39,415,544	0	39,415,544	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	10,061,482		10,061,482			30.00
31.00	03100	INTENSIVE CARE UNIT	4,425,869		4,425,869			31.00
43.00	04300	NURSERY	1,036,425		1,036,425			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,173,293	13,441,538	16,614,831	0.286865	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,830,612	8,409	1,839,021	0.883457	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,016,192	21,510,994	23,527,186	0.185969	0.000000	54.00
60.00	06000	LABORATORY	3,050,056	17,881,093	20,931,149	0.208843	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,617,449	920,417	4,537,866	0.190956	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	834,136	3,080,909	3,915,045	0.433217	0.000000	66.00
66.01	06601	CARDIAC REHAB	5,867	475,244	481,111	0.766285	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	253,325	1,060,553	1,313,878	0.106894	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	585	959,098	959,683	0.101573	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,716,550	4,153,775	5,870,325	0.410816	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,741,584	1,124,969	3,866,553	0.302022	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,381,554	4,310,677	6,692,231	0.488780	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	170	234,544	234,714	0.436029	0.000000	90.00
91.00	09100	EMERGENCY	2,284,787	10,197,205	12,481,992	0.226419	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,118,399	2,118,399	0.353440	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,757,465	5,757,465	0.319044	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	1,016,253	1,016,253			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	22,097	682,396	704,493			116.00
200.00		Subtotal (see instructions)	39,452,033	88,933,938	128,385,971			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,452,033	88,933,938	128,385,971			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I | Date/Time Prepared: 2/23/2016 3:08 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 10/01/2014 To 09/30/2015 | Worksheet D Part I Date/Time Prepared: 2/23/2016 3:08 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	522,757	0	522,757	5,885	88.83	30.00
31.00	INTENSIVE CARE UNIT	215,686		215,686	1,461	147.63	31.00
43.00	NURSERY	37,548		37,548	950	39.52	43.00
200.00	Total (lines 30-199)	775,991		775,991	8,296		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	1,715	152,343	30.00
31.00	INTENSIVE CARE UNIT	557	82,230	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	2,272	234,573	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/23/2016 3:08 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	687,672	16,614,831	0.041389	734,789	30,412	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	487,158	1,839,021	0.264901	7,324	1,940	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	389,273	23,527,186	0.016546	1,280,825	21,193	54.00
60.00	06000	LABORATORY	233,720	20,931,149	0.011166	1,436,328	16,038	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	51,898	4,537,866	0.011437	1,762,830	20,161	65.00
66.00	06600	PHYSICAL THERAPY	197,984	3,915,045	0.050570	315,483	15,954	66.00
66.01	06601	CARDIAC REHAB	97,622	481,111	0.202910	1,044	212	66.01
69.00	06900	ELECTROCARDIOLOGY	2,987	1,313,878	0.002273	103,669	236	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,110	959,683	0.002199	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	68,298	5,870,325	0.011634	564,194	6,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,638	3,866,553	0.003010	814,035	2,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,081	6,692,231	0.010920	929,182	10,147	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,099	234,714	0.008943	0	0	90.00
91.00	09100	EMERGENCY	317,782	12,481,992	0.025459	861,936	21,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	82,255	2,118,399	0.038829	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,705,577	105,383,984		8,811,639	147,251	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/23/2016 3:08 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	5,885	0.00	1,715	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,461	0.00	557	0	31.00
43.00	04300	NURSERY	950	0.00	0	0	43.00
200.00		Total (lines 30-199)	8,296		2,272	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 3:08 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 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 3:08 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	16,614,831	0.000000	0.000000	734,789	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,839,021	0.000000	0.000000	7,324	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,527,186	0.000000	0.000000	1,280,825	54.00
60.00	06000	LABORATORY	0	20,931,149	0.000000	0.000000	1,436,328	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	4,537,866	0.000000	0.000000	1,762,830	65.00
66.00	06600	PHYSICAL THERAPY	0	3,915,045	0.000000	0.000000	315,483	66.00
66.01	06601	CARDIAC REHAB	0	481,111	0.000000	0.000000	1,044	66.01
69.00	06900	ELECTROCARDIOLOGY	0	1,313,878	0.000000	0.000000	103,669	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	959,683	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	5,870,325	0.000000	0.000000	564,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,866,553	0.000000	0.000000	814,035	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,692,231	0.000000	0.000000	929,182	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	234,714	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	12,481,992	0.000000	0.000000	861,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,118,399	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	105,383,984			8,811,639	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 3:08 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	2,412,085	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,115,326	0	54.00
60.00	06000	LABORATORY	0	1,436,784	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	174,144	0	65.00
66.00	06600	PHYSICAL THERAPY	0	967	0	66.00
66.01	06601	CARDIAC REHAB	0	133,414	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	248,490	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	247,526	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	480,297	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	188,281	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,431,192	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	63,257	0	90.00
91.00	09100	EMERGENCY	0	1,681,787	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	549,907	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	13,163,457	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.286865	2,412,085	0	0	691,943	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.883457	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185969	4,115,326	0	0	765,323	54.00
60.00	06000	LABORATORY	0.208843	1,436,784	1,415	0	300,062	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.190956	174,144	0	0	33,254	65.00
66.00	06600	PHYSICAL THERAPY	0.433217	967	0	0	419	66.00
66.01	06601	CARDIAC REHAB	0.766285	133,414	0	0	102,233	66.01
69.00	06900	ELECTROCARDIOLOGY	0.106894	248,490	0	0	26,562	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101573	247,526	0	0	25,142	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.410816	480,297	0	0	197,314	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302022	188,281	0	0	56,865	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488780	1,431,192	0	13,592	699,538	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.436029	63,257	0	0	27,582	90.00
91.00	09100	EMERGENCY	0.226419	1,681,787	0	0	380,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.353440	549,907	0	0	194,359	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.319044		0			95.00
200.00		Subtotal (see instructions)		13,163,457	1,415	13,592	3,501,385	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		13,163,457	1,415	13,592	3,501,385	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	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	296	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	6,643	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)	296	6,643	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	296	6,643	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/23/2016 3:08 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)	5,885	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,885	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)	4,959	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)	1,715	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)	4,758,389	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)	4,758,389	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)	4,758,389	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)	808.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,386,680	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)	1,386,680	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 3:08 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	2,250,091	1,461	1,540.10	557	857,836	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)	2,367,555	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,612,071	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)	234,573	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	147,251	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	381,824	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,230,247	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	926	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	808.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	748,727	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 3:08 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	522,757	4,758,389	0.109860	748,727	82,255	90.00
91.00	Nursing School cost	0	4,758,389	0.000000	748,727	0	91.00
92.00	Allied health cost	0	4,758,389	0.000000	748,727	0	92.00
93.00	All other Medical Education	0	4,758,389	0.000000	748,727	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/23/2016 3:08 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)	5,885	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,885	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)	4,959	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)	316	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)	950	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)	4,758,389	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)	4,758,389	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)	4,758,389	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)	808.56	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	255,505	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)	255,505	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 3:08 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)	482,391	950	507.78	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,250,091	1,461	1,540.10	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)	236,087	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	491,592	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	926	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	808.56	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	748,727	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 3:08 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	522,757	4,758,389	0.109860	748,727	82,255	90.00
91.00	Nursing School cost	0	4,758,389	0.000000	748,727	0	91.00
92.00	Allied health cost	0	4,758,389	0.000000	748,727	0	92.00
93.00	All other Medical Education	0	4,758,389	0.000000	748,727	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/23/2016 3:08 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		3,470,962		30.00
31.00	03100	INTENSIVE CARE UNIT		1,784,055		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.286865	734,789	210,785	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.883457	7,324	6,470	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185969	1,280,825	238,194	54.00
60.00	06000	LABORATORY	0.208843	1,436,328	299,967	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.190956	1,762,830	336,623	65.00
66.00	06600	PHYSICAL THERAPY	0.433217	315,483	136,673	66.00
66.01	06601	CARDIAC REHAB	0.766285	1,044	800	66.01
69.00	06900	ELECTROCARDIOLOGY	0.106894	103,669	11,082	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101573	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.410816	564,194	231,780	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302022	814,035	245,856	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488780	929,182	454,166	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.436029	0	0	90.00
91.00	09100	EMERGENCY	0.226419	861,936	195,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.353440	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)		8,811,639	2,367,555	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)		8,811,639		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 Date/Time Prepared: 2/23/2016 3:08 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		209,110		30.00
31.00	03100	INTENSIVE CARE UNIT		194,424		31.00
43.00	04300	NURSERY		401,916		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.286865	27,586	7,913	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.883457	64,166	56,688	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185969	61,809	11,495	54.00
60.00	06000	LABORATORY	0.208843	211,619	44,195	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.190956	162,787	31,085	65.00
66.00	06600	PHYSICAL THERAPY	0.433217	48,915	21,191	66.00
66.01	06601	CARDIAC REHAB	0.766285	246	189	66.01
69.00	06900	ELECTROCARDIOLOGY	0.106894	6,742	721	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.101573	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.410816	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.302022	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.488780	92,441	45,183	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.436029	0	0	90.00
91.00	09100	EMERGENCY	0.226419	76,969	17,427	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.353440	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)		753,280	236,087	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)		753,280		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/23/2016 3:08 pm

		Title XVIII		Hospital	PPS	
			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,391,476			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		42,440			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)		34.46			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A | Date/Time Prepared: 2/23/2016 3:08 pm

	Title XVIII		Hospital	PPS		
			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.01			30.00
31.00	Percentage of Medicaid patient days (see instructions)		21.62			31.00
32.00	Sum of lines 30 and 31		24.63			32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.53			33.00
34.00	Disproportionate share adjustment (see instructions)		80,802			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000044923	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		343,555	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		343,555	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		343,555			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		3,858,273			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0			48.00
49.00	Total payment for inpatient operating costs (see instructions)		3,858,273			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		271,597			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,129,870			59.00
60.00	Primary payer payments		4,601			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,125,269			61.00
62.00	Deductibles billed to program beneficiaries		596,780			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		18,574			63.00
64.00	Allowable bad debts (see instructions)		74,237			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		48,254			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		27,372			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,558,169			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		3,818			70.93
70.94	HRR adjustment amount (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)	2015	488,948			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,050,935			71.00
71.01	Sequestration adjustment (see instructions)		81,019			71.01
72.00	Interim payments		4,051,775			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)		-81,859			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		148,223			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/23/2016 3:08 pm

		Title XVIII	Hospital	PPS	
		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)			0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,391,476	0	0	3,391,476	3,391,476	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	42,440	0	0	42,440	42,440	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0953	0.0953	0.0953	0.0953		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	80,802	0	0	80,802	80,802	11.00
11.01	Uncompensated care payments	36.00	343,555	0	0	343,555	343,555	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	3,858,273	0	0	3,858,273	3,858,273	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,858,273	0	0	3,858,273	3,858,273	15.00
16.00	Payment for inpatient program capital	50.00	271,597	0	0	271,597	271,597	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	0	4,129,870	4,129,870	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	266,802	0	0	266,802	266,802	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	4,795	0	0	4,795	4,795	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	271,597	0	0	271,597	271,597	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	0.118393		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				488,948	488,948	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/23/2016 3:08 pm
	Title XVIII	Hospital	PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,391,476		3,391,476	3,391,476	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	42,440	0	42,440	42,440	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0953	0.0953	0.0953		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	80,802	0	80,802	80,802	11.00
11.01	Uncompensated care payments	36.00	343,555	0	343,555	343,555	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,858,273	0	3,858,273	3,858,273	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,858,273	0	3,858,273	3,858,273	15.00
16.00	Payment for inpatient program capital	50.00	271,597	0	271,597	271,597	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,129,870	4,129,870	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	266,802	0	266,802	266,802	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	4,795	0	4,795	4,795	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	271,597	0	271,597	271,597	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	488,948		488,948	488,948	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	3,818	0	3,818	3,818	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E Part B Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,939	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,501,385	2.00
3.00	PPS payments	2,940,609	3.00
4.00	Outlier payment (see instructions)	6,074	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,939	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	15,007	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	15,007	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)	15,007	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	8,068	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)	6,939	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)	2,946,683	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)	675,543	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,278,079	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,278,079	30.00
31.00	Primary payer payments	661	31.00
32.00	Subtotal (line 30 minus line 31)	2,277,418	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	130,246	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	84,660	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	74,102	36.00
37.00	Subtotal (see instructions)	2,362,078	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-24	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,362,102	40.00
40.01	Sequestration adjustment (see instructions)	47,242	40.01
41.00	Interim payments	2,230,645	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	84,215	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 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 2/23/2016 3:08 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		4,051,775		2,230,645	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)		4,051,775		2,230,645	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		84,215	6.01
6.02	SETTLEMENT TO PROGRAM		81,859		0	6.02
7.00	Total Medicare program liability (see instructions)		3,969,916		2,314,860	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 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/23/2016 3:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,379	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,272	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,557	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,420	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	128,385,971	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,149,563	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	337,911	8.00
9.00	Sequestration adjustment amount (see instructions)	6,758	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	331,153	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	267,448	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)	63,705	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 2/23/2016 3:08 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	491,592		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)	491,592	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)	491,592	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	805,451		8.00
9.00	Ancillary service charges	753,280	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)	1,558,731	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)	1,558,731	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,067,139	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)	491,592	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)	491,592	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)	491,592	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)	491,592	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	491,592	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)	491,592	0	40.00
41.00	Interim payments	587,877	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-96,285	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 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/23/2016 3:08 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	29,899	0	0	0	1.00
2.00	Temporary investments	37,166	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,161,780	0	0	0	4.00
5.00	Other receivable	351,690	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,472,912	0	0	0	6.00
7.00	Inventory	1,596,794	0	0	0	7.00
8.00	Prepaid expenses	721,293	0	0	0	8.00
9.00	Other current assets	133,011	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)	10,558,721	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	393,118	0	0	0	12.00
13.00	Land improvements	1,781,970	0	0	0	13.00
14.00	Accumulated depreciation	-1,423,790	0	0	0	14.00
15.00	Buildings	60,294,655	0	0	0	15.00
16.00	Accumulated depreciation	-27,425,168	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-1,493,579	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	-209,343	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	24,276,380	0	0	0	23.00
24.00	Accumulated depreciation	-15,157,030	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	-206,027	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)	40,831,186	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	17,575,039	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,575,039	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,964,946	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,858,585	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,334,369	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,713,540	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	1,000,682	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,907,176	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,276,305	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	13,276,305	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	21,183,481	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	47,781,465				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)	47,781,465	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,964,946	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 Date/Time Prepared: 2/23/2016 3:08 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		49,374,669		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,589,874				2.00
3.00	Total (sum of line 1 and line 2)		46,784,795		0		3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	1,530,360		0		0	4.00
5.00	CONTRIBUTIONS RECEIVED	1,051,118		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)		2,581,478		0		10.00
11.00	Subtotal (line 3 plus line 10)		49,366,273		0		11.00
12.00	NET ASSETS RELEASED FROM RESTRICTION	1,584,808		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)		1,584,808		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		47,781,465		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 ASSETS RELEASED FROM RESTRICTION		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 ASSETS RELEASED FROM RESTRICTION		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 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2016 3:08 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,097,907		11,097,907	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)	11,097,907		11,097,907	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,425,869		4,425,869	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)	4,425,869		4,425,869	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,523,776		15,523,776	17.00
18.00	Ancillary services	21,621,204	68,901,043	90,522,247	18.00
19.00	Outpatient services	2,284,958	12,550,149	14,835,107	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		1,016,253	1,016,253	22.00
23.00	AMBULANCE SERVICES	0	5,757,465	5,757,465	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	22,097	682,396	704,493	26.00
27.00	DIETARY	11	26,848	26,859	27.00
27.01	DHMG PHYSICIANS	0	12,286,838	12,286,838	27.01
27.02	SELF-INSURANCE	377,614	1,418,415	1,796,029	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	39,829,660	102,639,407	142,469,067	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		62,665,523		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)		62,665,523		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/23/2016 3:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	142,469,067	1.00
2.00	Less contractual allowances and discounts on patients' accounts	86,675,292	2.00
3.00	Net patient revenues (line 1 minus line 2)	55,793,775	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	62,665,523	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,871,748	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-1,542,122	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	5,823,996	24.00
25.00	Total other income (sum of lines 6-24)	4,281,874	25.00
26.00	Total (line 5 plus line 25)	-2,589,874	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)	-2,589,874	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H | Date/Time Prepared: 2/23/2016 3:08 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	339,293	257,765	36,064	65,792	13,304	712,218	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	182,225	0	0	0	0	182,225	6.00
7.00	Physical Therapy	111,220	0	0	0	0	111,220	7.00
8.00	Occupational Therapy	4,420	0	0	0	0	4,420	8.00
9.00	Speech Pathology	4,923	0	0	0	0	4,923	9.00
10.00	Medical Social Services	23,947	0	0	0	0	23,947	10.00
11.00	Home Health Aide	57,406	0	0	0	0	57,406	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)	723,434	257,765	36,064	65,792	13,304	1,096,359	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	9,707	721,925	-48,395	673,530	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	182,225	0	182,225	6.00
7.00	Physical Therapy	0	111,220	0	111,220	7.00
8.00	Occupational Therapy	0	4,420	0	4,420	8.00
9.00	Speech Pathology	0	4,923	0	4,923	9.00
10.00	Medical Social Services	0	23,947	0	23,947	10.00
11.00	Home Health Aide	0	57,406	0	57,406	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	9,707	1,106,066	-48,395	1,057,671	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 10/01/2014 To 09/30/2015 | Worksheet H-1 Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Home Health Agency I | PPS

			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	673,530	0	0	0	0	673,530	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	182,225	0	0	0	0	182,225	6.00
7.00	Physical Therapy	111,220	0	0	0	0	111,220	7.00
8.00	Occupational Therapy	4,420	0	0	0	0	4,420	8.00
9.00	Speech Pathology	4,923	0	0	0	0	4,923	9.00
10.00	Medical Social Services	23,947	0	0	0	0	23,947	10.00
11.00	Home Health Aide	57,406	0	0	0	0	57,406	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)	1,057,671	0	0	0	0	1,057,671	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	673,530		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	319,502	501,727	6.00
7.00	Physical Therapy	195,007	306,227	7.00
8.00	Occupational Therapy	7,750	12,170	8.00
9.00	Speech Pathology	8,632	13,555	9.00
10.00	Medical Social Services	41,987	65,934	10.00
11.00	Home Health Aide	100,652	158,058	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)		1,057,671	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-1 Part II | Date/Time Prepared: 2/23/2016 3:08 pm

Home Health Agency I | PPS

		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	-673,530	384,141	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	182,225	6.00
7.00	Physical Therapy	0	0	0	0	0	111,220	7.00
8.00	Occupational Therapy	0	0	0	0	0	4,420	8.00
9.00	Speech Pathology	0	0	0	0	0	4,923	9.00
10.00	Medical Social Services	0	0	0	0	0	23,947	10.00
11.00	Home Health Aide	0	0	0	0	0	57,406	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	-673,530	384,141	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		673,530	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.753341	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Home Health Agency I | PPS

	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	2,420	0	0	1.00
2.00	Skilled Nursing Care	501,727	0	0	0	0	0	2.00
3.00	Physical Therapy	306,227	0	0	0	0	0	3.00
4.00	Occupational Therapy	12,170	0	0	0	0	0	4.00
5.00	Speech Pathology	13,555	0	0	0	0	0	5.00
6.00	Medical Social Services	65,934	0	0	0	0	0	6.00
7.00	Home Health Aide	158,058	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)	1,057,671	0	0	2,420	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	29,248	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	29,248	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 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Home Health Agency I | PPS

	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	31,668	5,340	80,882	0	23,802	0	1.00
2.00	Skilled Nursing Care	501,727	84,606	0	0	0	0	2.00
3.00	Physical Therapy	306,227	51,640	0	0	0	0	3.00
4.00	Occupational Therapy	12,170	2,052	0	0	0	0	4.00
5.00	Speech Pathology	13,555	2,286	0	0	0	0	5.00
6.00	Medical Social Services	65,934	11,119	0	0	0	0	6.00
7.00	Home Health Aide	158,058	26,654	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)	1,089,339	183,697	80,882	0	23,802	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	31,013	131,433	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	31,013	131,433	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 10/01/2014 To 09/30/2015

Worksheet H-2 Part I
Date/Time Prepared: 2/23/2016 3:08 pm

Home Health Agency I | PPS

	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	304,138	0	304,138			1.00
2.00	Skilled Nursing Care	0	586,333	0	586,333	144,274	730,607	2.00
3.00	Physical Therapy	0	357,867	0	357,867	88,057	445,924	3.00
4.00	Occupational Therapy	0	14,222	0	14,222	3,499	17,721	4.00
5.00	Speech Pathology	0	15,841	0	15,841	3,898	19,739	5.00
6.00	Medical Social Services	0	77,053	0	77,053	18,960	96,013	6.00
7.00	Home Health Aide	0	184,712	0	184,712	45,450	230,162	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	1,540,166	0	1,540,166	304,138	1,540,166	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.					0.246061		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 10/01/2014 To 09/30/2015 | Worksheet H-2 Part II | Date/Time Prepared: 2/23/2016 3:08 pm

Home Health Agency I | PPS

	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	2,420	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.873016	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	722,932	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	722,932		20.00
21.00	Total cost to be allocated	0	0	0	0	29,248		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.040457		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part II | Date/Time Prepared: 2/23/2016 3:08 pm

Home Health Agency I | PPS

	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	31,668	2,772	0	2,772	0	0	1.00
2.00	Skilled Nursing Care	501,727	0	0	0	0	0	2.00
3.00	Physical Therapy	306,227	0	0	0	0	0	3.00
4.00	Occupational Therapy	12,170	0	0	0	0	0	4.00
5.00	Speech Pathology	13,555	0	0	0	0	0	5.00
6.00	Medical Social Services	65,934	0	0	0	0	0	6.00
7.00	Home Health Aide	158,058	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)	1,089,339	2,772	0	2,772	0	0	20.00
21.00	Total cost to be allocated	183,697	80,882	0	23,802	0	0	21.00
22.00	Unit cost multiplier	0.168632	29.178211	0.000000	8.586580	0.000000	0.000000	22.00

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	1,486	30,919	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)	1,486	30,919	0	0	0	0	20.00
21.00	Total cost to be allocated	31,013	131,433	0	0	0	0	21.00
22.00	Unit cost multiplier	20.870121	4.250881	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 2/23/2016 3:08 pm

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	730,607		730,607	3,853	189.62	1.00
2.00	Physical Therapy	3.00	445,924	0	445,924	1,384	322.20	2.00
3.00	Occupational Therapy	4.00	17,721	0	17,721	55	322.20	3.00
4.00	Speech Pathology	5.00	19,739	0	19,739	40	493.48	4.00
5.00	Medical Social Services	6.00	96,013		96,013	116	827.70	5.00
6.00	Home Health Aide	7.00	230,162		230,162	1,166	197.39	6.00
7.00	Total (sum of lines 1-6)		1,540,166	0	1,540,166	6,614		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: 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	0	490			8.00
8.01	Skilled Nursing Care		50031	0	1,227			8.01
9.00	Physical Therapy		99915	0	170			9.00
9.01	Physical Therapy		50031	0	471			9.01
10.00	Occupational Therapy		99915	0	5			10.00
10.01	Occupational Therapy		50031	0	13			10.01
11.00	Speech Pathology		99915	0	11			11.00
11.01	Speech Pathology		50031	0	8			11.01
12.00	Medical Social Services		99915	0	23			12.00
12.01	Medical Social Services		50031	0	29			12.01
13.00	Home Health Aide		99915	0	149			13.00
13.01	Home Health Aide		50031	0	386			13.01
14.00	Total (sum of lines 8-13)			0	2,982			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	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,717		0	325,578		1.00
2.00	Physical Therapy	0	641		0	206,530		2.00
3.00	Occupational Therapy	0	18		0	5,800		3.00
4.00	Speech Pathology	0	19		0	9,376		4.00
5.00	Medical Social Services	0	52		0	43,040		5.00
6.00	Home Health Aide	0	535		0	105,604		6.00
7.00	Total (sum of lines 1-6)	0	2,982		0	695,928		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Home Health Agency I | PPS

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

	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	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of 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	325,578	1.00
2.00	Physical Therapy	206,530	2.00
3.00	Occupational Therapy	5,800	3.00
4.00	Speech Pathology	9,376	4.00
5.00	Medical Social Services	43,040	5.00
6.00	Home Health Aide	105,604	6.00
7.00	Total (sum of lines 1-6)	695,928	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part II | Date/Time Prepared: 2/23/2016 3:08 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.433217	0	0	col. 2, line 2.00	1.00
1.01	Physical Therapy 1	66.01	0.766285	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	0.410816	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.488780	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 150045 HHA CCN: 157157	Period: From 10/01/2014 To 09/30/2015	Worksheet H-4 Part I-II Date/Time Prepared: 2/23/2016 3:08 pm
	Title XVIII	Home Health Agency I	PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	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	0	408,501	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	9,103	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,597	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,119	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,226	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	434,546	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	434,546	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	434,546	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	434,546	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	434,546	31.00
31.01	Sequestration adjustment (see instructions)	0	8,691	31.01
32.00	Interim payments (see instructions)	0	425,855	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 150045 | HHA CCN: 157157 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-5 | Date/Time Prepared: 2/23/2016 3:08 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		0		425,855	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		425,855	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		425,855	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 10/01/2014 To 09/30/2015 | Worksheet K | Date/Time Prepared: 2/23/2016 3:08 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	1,854	0	11,103	95,782	116,979	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	20,803	0	0	0	0	9.00
10.00	Nursing Care	87,678	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	69	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	3,392	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	20,536	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)	134,332	0	11,103	95,782	116,979	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150045 | Hospice CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K | Date/Time Prepared: 2/23/2016 3:08 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	225,718	1,012	226,730	-217	226,513	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	20,803	0	20,803	0	20,803	9.00
10.00	Nursing Care	87,678	0	87,678	0	87,678	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	69	0	69	0	69	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	3,392	0	3,392	0	3,392	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	20,536	0	20,536	0	20,536	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)	358,196	1,012	359,208	-217	358,991	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150045 | Hospice CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-1 | Date/Time Prepared: 2/23/2016 3:08 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	1,854	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	87,678	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)	1,854	0	0	0	87,678	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150045 | Hospice CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-1 | Date/Time Prepared: 2/23/2016 3:08 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	1,854		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	20,803	20,803		9.00
10.00	Nursing Care		0	0	87,678		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	69	0	0	69		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	3,392	3,392		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		20,536	0	20,536		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)	69	20,536	24,195	134,332		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 150045 | Hospice CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-3 | Date/Time Prepared: 2/23/2016 3:08 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 10/01/2014 To 09/30/2015 | Worksheet K-3 | Date/Time Prepared: 2/23/2016 3:08 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	95,782	95,782		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	95,782	95,782		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150045 | Hospice CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part I | Date/Time Prepared: 2/23/2016 3:08 pm

Hospice I

			CAPITAL RELATED COST				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
		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	226,513	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	20,803	0	0	0	0	9.00
10.00	Nursing Care	87,678	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	69	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	3,392	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	20,536	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)	358,991	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150045 | Hospice CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part I | Date/Time Prepared: 2/23/2016 3:08 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	226,513	226,513			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	20,803	35,569	56,372		9.00
10.00	Nursing Care	0	87,678	149,913	237,591		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	69	118	187		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	3,392	5,800	9,192		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	20,536	35,113	55,649		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	358,991		358,991		39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150045 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-4 Part II
Hospice CCN: 151559 | Date/Time Prepared: 2/23/2016 3:08 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 10/01/2014 To 09/30/2015 | Worksheet K-4 Part II | Date/Time Prepared: 2/23/2016 3:08 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	-226,513	132,478	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	20,803	9.00
10.00	Nursing Care	0	87,678	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	69	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	0	15.00
16.00	Spiritual Counseling	0	3,392	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	20,536	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)		226,513	39.00
40.00	Unit Cost Multiplier		1.709816	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150045 | Hospice CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-5 Part I | Date/Time Prepared: 2/23/2016 3:08 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	262	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	56,372	0	0	0	0	4.00
5.00	Nursing Care	237,591	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	187	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	9,192	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	55,649	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)	358,991	0	0	262	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 10/01/2014 To 09/30/2015 | Worksheet K-5 Part I | Date/Time Prepared: 2/23/2016 3:08 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 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-5 Part I
Hospice CCN: 151559 | Date/Time Prepared: 2/23/2016 3:08 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	5,431	5,693	960	8,753	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	56,372	9,506	0	4.00
5.00	Nursing Care	0	0	237,591	40,065	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	187	32	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	9,192	1,550	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	55,649	9,384	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	5,431	364,684	61,497	8,753	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 10/01/2014 To 09/30/2015

Worksheet K-5 Part I | Date/Time Prepared: 2/23/2016 3:08 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	94	2,576	0	0	3,569	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)	94	2,576	0	0	3,569	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 10/01/2014 To 09/30/2015 | Worksheet K-5 Part I | Date/Time Prepared: 2/23/2016 3:08 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	15,082	0	0	5,687	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)	15,082	0	0	5,687	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 10/01/2014
To 09/30/2015

Worksheet K-5
Part I
Date/Time Prepared:
2/23/2016 3:08 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	42,414					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	65,878	0	65,878	6,660	72,538	4.00
5.00	Nursing Care	277,656	0	277,656	28,071	305,727	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	219	0	219	22	241	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	10,742	0	10,742	1,086	11,828	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	65,033	0	65,033	6,575	71,608	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)	461,942	0	461,942		461,942	34.00
35.00	Unit Cost Multiplier (see instructions)				0.101099		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559
Period: From 10/01/2014 To 09/30/2015
Worksheet K-5 Part II
Date/Time Prepared: 2/23/2016 3:08 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	262	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.873333	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 10/01/2014 To 09/30/2015 | Worksheet K-5 Part II | Date/Time Prepared: 2/23/2016 3:08 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 10/01/2014 To 09/30/2015 | Worksheet K-5 Part II | Date/Time Prepared: 2/23/2016 3:08 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	134,238	0	5,693	300	172	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	56,372	0	0	4.00
5.00	Nursing Care	0	0	237,591	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	187	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	9,192	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	55,649	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)	134,238		364,684	300	172	34.00
35.00	Total cost to be allocated	5,431		61,497	8,753	94	35.00
36.00	Unit Cost Multiplier (see instructions)	0.040458		0.168631	29.176667	0.546512	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

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

Worksheet K-5
Part II
Date/Time Prepared:
2/23/2016 3:08 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	171	3,548	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	171	3,548	34.00
35.00	Total cost to be allocated	2,576	0	0	3,569	15,082	35.00
36.00	Unit Cost Multiplier (see instructions)	8.586667	0.000000	0.000000	20.871345	4.250846	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150045
Hospice CCN: 151559

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

Worksheet K-5
Part II
Date/Time Prepared:
2/23/2016 3:08 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	715,591	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	715,591	0		34.00
35.00	Total cost to be allocated	0	0	5,687	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.007947	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150045 | Hospice CCN: 151559 | Period: From 10/01/2014 To 09/30/2015 | Worksheet K-5 Part III | Date/Time Prepared: 2/23/2016 3:08 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	0.433217	0	0	1.00
1.01	CARDIAC REHAB	66.01	0.766285	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	0.488780	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.208843	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	0.410816	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 10/01/2014 To 09/30/2015 | Worksheet K-6 | Date/Time Prepared: 2/23/2016 3:08 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				461,942	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,676	2.00
3.00	Average cost per diem (line 1 divided by line 2)				125.66	3.00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,676				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	461,926				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	856				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	107,565				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)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150045	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/23/2016 3:08 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	266,802	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	4,795	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)	18.22	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	271,597	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