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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 15-0045

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

Worksheet S
Parts I-III
Date/Time Prepared:
2/23/2017 4:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/23/2017 Time: 4:58 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 (15-0045) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-51,883	87,423	0	-124,707	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00	Total	0	-51,883	87,422	0	-124,707	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2017 4:56 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:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	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.	267	482	0	11	844	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: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 4:56 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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 4:56 pm

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

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

		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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 4:56 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
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 4:56 pm

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 4:56 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	12/29/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2017 4:56 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	11/23/2016	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		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/16/2017	Y	02/16/2017	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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/23/2017 4:56 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/23/2017 4:56 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2017 4:56 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	48	17,568	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)		48	17,568	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,928	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)		56	20,496	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	89.00				0	26.25
27.00	Total (sum of lines 14-26)		56				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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2017 4:56 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)	1,763	267	4,972			1.00
2.00	HMO and other (see instructions)	1,523	1,337				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)	1,763	267	4,972			7.00
8.00	INTENSIVE CARE UNIT	461	0	1,490			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	860			13.00
14.00	Total (see instructions)	2,224	267	7,322	0.00	488.22	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	3,167	0	9,024	0.00	13.74	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	64	0.00	1.03	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	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	502.99	27.00
28.00	Observation Bed Days		19	1,501			28.00
29.00	Ambulance Trips	1,190					29.00
30.00	Employee discount days (see instruction)			92			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	3			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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2017 4:56 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	667	56	2,179	1.00
2.00	HMO and other (see instructions)			427	359		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	667	56	2,179	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	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2017 4:56 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	27,340,435	0	27,340,435	1,043,248.00	26.21	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		278,550	0	278,550	2,116.00	131.64	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		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 and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		8,727,896	0	8,727,896	264,716.00	32.97	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,049,370	0	1,049,370	17,300.00	60.66	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		383,345	0	383,345	2,046.00	187.36	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,853,903	0	5,853,903			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,048,940	0	2,048,940			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		20,848	0	20,848			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
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	234,489	0	234,489	7,481.00	31.34	26.00
27.00	Administrative & General	5.00	3,623,118	0	3,623,118	174,753.00	20.73	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II | Date/Time Prepared: 2/23/2017 4:56 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	
28.00	Administrative & General under contract (see inst.)		238,625	0	238,625	1,228.00	194.32	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	576,302	0	576,302	23,957.00	24.06	30.00
31.00	Laundry & Linen Service	8.00	16,181	0	16,181	2,040.00	7.93	31.00
32.00	Housekeeping	9.00	683,583	0	683,583	51,527.00	13.27	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	582,872	-350,420	232,452	10,936.00	21.26	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	350,420	350,420	23,488.00	14.92	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	825,105	0	825,105	22,625.00	36.47	38.00
39.00	Central Services and Supply	14.00	89,571	0	89,571	5,573.00	16.07	39.00
40.00	Pharmacy	15.00	516,534	0	516,534	12,295.00	42.01	40.00
41.00	Medical Records & Medical Records Library	16.00	499,678	0	499,678	26,728.00	18.69	41.00
42.00	Social Service	17.00	71,811	0	71,811	2,067.00	34.74	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet S-3 Part III Date/Time Prepared: 2/23/2017 4:56 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)		27,579,060	0	27,579,060	1,044,476.00	26.40	1.00
2.00	Excluded area salaries (see instructions)		8,727,896	0	8,727,896	264,716.00	32.97	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,851,164	0	18,851,164	779,760.00	24.18	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,432,715	0	1,432,715	19,346.00	74.06	4.00
5.00	Subtotal wage-related costs (see inst.)		5,874,751	0	5,874,751	0.00	31.16	5.00
6.00	Total (sum of lines 3 thru 5)		26,158,630	0	26,158,630	799,106.00	32.73	6.00
7.00	Total overhead cost (see instructions)		7,957,869	0	7,957,869	364,698.00	21.82	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 2/23/2017 4:56 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	102,470	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	1,500	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)	5,431,702	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	61,887	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)	69,733	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	295,952	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	1,844,270	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	17,572	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	98,604	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,923,690	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 2/23/2017 4:56 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: 15-0045 | Component CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-4 | Date/Time Prepared: 2/23/2017 4:56 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	181.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		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).		50031			20.00
20.01			99915			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	1,544	112	68	30	1,754	21.00
22.00	Skilled Nursing Visit Charges	289,734	21,000	12,750	5,625	329,109	22.00
23.00	Physical Therapy Visits	697	4	5	17	723	23.00
24.00	Physical Therapy Visit Charges	125,955	742	928	3,154	130,779	24.00
25.00	Occupational Therapy Visits	111	6	0	0	117	25.00
26.00	Occupational Therapy Visit Charges	20,063	1,125	0	0	21,188	26.00
27.00	Speech Pathology Visits	25	0	1	0	26	27.00
28.00	Speech Pathology Visit Charges	4,981	0	199	0	5,180	28.00
29.00	Medical Social Service Visits	8	1	1	0	10	29.00
30.00	Medical Social Service Visit Charges	2,280	285	285	0	2,850	30.00
31.00	Home Health Aide Visits	506	21	2	8	537	31.00
32.00	Home Health Aide Visit Charges	56,293	2,336	223	890	59,742	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,891	144	77	55	3,167	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)	499,306	25,488	14,385	9,669	548,848	35.00
36.00	Total Number of Episodes (standard/non outlier)	179		29	4	212	36.00
37.00	Total Number of Outlier Episodes		5		0	5	37.00
38.00	Total Non-Routine Medical Supply Charges	17,694	14,812	0	14	32,520	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-9 PARTS I THROUGH IV | Date/Time Prepared: 2/23/2017 4:56 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 FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

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

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	2,889	87	1,036	4,012	11.00
12.00	Hospice Inpatient Respite Care	9	0	0	9	12.00
13.00	Hospice General Inpatient Care	52	16	16	84	13.00
14.00	Total Hospice Days	2,950	103	1,052	4,105	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet S-10 Date/Time Prepared: 2/23/2017 4:56 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)	0.305480	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,376,759	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	20,472,935	6.00
7.00	Medicaid cost (line 1 times line 6)	6,254,072	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)	1,877,313	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	209,233	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,877,313	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	904,000	0	904,000	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	276,154	0	276,154	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)	276,154	0	276,154	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)	5,648,118	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	101,490	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,546,628	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,694,384	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,970,538	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,847,851	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/23/2017 4:56 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		5,342,102	5,342,102	0	5,342,102	1.00
1.01	00101	MAC WEST - NEW		23,501	23,501	0	23,501	1.01
1.02	00102	NORTH ANNEX - NEW		4,584	4,584	0	4,584	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		150,192	150,192	0	150,192	1.05
1.06	00106	GARRETT LAB - NEW		0	0	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW		43,183	43,183	0	43,183	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	234,489	438,693	673,182	0	673,182	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,623,118	6,855,519	10,478,637	-9,317	10,469,320	5.00
7.00	00700	OPERATION OF PLANT	576,302	1,576,184	2,152,486	0	2,152,486	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,181	7,868	24,049	0	24,049	8.00
9.00	00900	HOUSEKEEPING	683,583	496,812	1,180,395	0	1,180,395	9.00
10.00	01000	DIETARY	559,878	538,629	1,098,507	-700,270	398,237	10.00
10.01	01001	SNACK BAR	22,994	36,021	59,015	0	59,015	10.01
11.00	01100	CAFETERIA	0	0	0	700,270	700,270	11.00
13.00	01300	NURSING ADMINISTRATION	825,105	172,403	997,508	0	997,508	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,571	119,825	209,396	0	209,396	14.00
15.00	01500	PHARMACY	516,534	48,984	565,518	0	565,518	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	499,678	159,853	659,531	0	659,531	16.00
17.00	01700	SOCIAL SERVICE	71,811	18,451	90,262	0	90,262	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,902,810	1,247,188	4,149,998	-795,629	3,354,369	30.00
31.00	03100	INTENSIVE CARE UNIT	969,366	583,108	1,552,474	0	1,552,474	31.00
43.00	04300	NURSERY	0	1,024	1,024	267,101	268,125	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,588,250	1,944,906	3,533,156	0	3,533,156	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	528,528	528,528	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,756,665	1,325,437	3,082,102	-25,107	3,056,995	54.00
60.00	06000	LABORATORY	1,287,928	2,261,256	3,549,184	0	3,549,184	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	527,684	152,121	679,805	0	679,805	65.00
66.00	06600	PHYSICAL THERAPY	320,975	1,162,883	1,483,858	-52,117	1,431,741	66.00
66.01	06601	CARDIAC REHAB	100,116	32,398	132,514	52,117	184,631	66.01
69.00	06900	ELECTROCARDIOLOGY	47,534	5,731	53,265	25,107	78,372	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,294	29,760	79,054	0	79,054	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,750,867	1,750,867	0	1,750,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,121,414	1,121,414	0	1,121,414	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,029,778	3,029,778	0	3,029,778	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	58,723	7,558	66,281	0	66,281	90.00
91.00	09100	EMERGENCY	1,283,950	457,270	1,741,220	0	1,741,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,155,404	527,478	1,682,882	0	1,682,882	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	744,256	406,627	1,150,883	5,275	1,156,158	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	79,924	205,204	285,128	571	285,699	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,592,123	32,313,313	52,905,436	-3,471	52,901,965	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	6,291,947	2,617,965	8,909,912	3,471	8,913,383	192.01
192.02	19202	PHARMACARE	447,163	3,942,139	4,389,302	0	4,389,302	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	9,202	4,288	13,490	0	13,490	194.02
200.00		TOTAL (SUM OF LINES 118-199)	27,340,435	38,877,705	66,218,140	0	66,218,140	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/23/2017 4:56 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	-383,778	4,958,324	1.00
1.01	00101	MAC WEST - NEW	0	23,501	1.01
1.02	00102	NORTH ANNEX - NEW	0	4,584	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	150,192	1.05
1.06	00106	GARRETT LAB - NEW	0	0	1.06
1.07	00107	MEDICAL ARTS - NEW	0	43,183	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	-1,585	671,597	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,717,752	8,751,568	5.00
7.00	00700	OPERATION OF PLANT	-3,928	2,148,558	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-896	23,153	8.00
9.00	00900	HOUSEKEEPING	-2,683	1,177,712	9.00
10.00	01000	DIETARY	-6,004	392,233	10.00
10.01	01001	SNACK BAR	-51,998	7,017	10.01
11.00	01100	CAFETERIA	-266,827	433,443	11.00
13.00	01300	NURSING ADMINISTRATION	-75	997,433	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	209,396	14.00
15.00	01500	PHARMACY	0	565,518	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,140	658,391	16.00
17.00	01700	SOCIAL SERVICE	0	90,262	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	-65,000	3,289,369	30.00
31.00	03100	INTENSIVE CARE UNIT	-59,625	1,492,849	31.00
43.00	04300	NURSERY	0	268,125	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-811,122	2,722,034	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	528,528	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-55,615	3,001,380	54.00
60.00	06000	LABORATORY	42	3,549,226	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-267	679,538	65.00
66.00	06600	PHYSICAL THERAPY	-24,654	1,407,087	66.00
66.01	06601	CARDIAC REHAB	-13,249	171,382	66.01
69.00	06900	ELECTROCARDIOLOGY	-1,200	77,172	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	79,054	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,750,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,121,414	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-201	3,029,577	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	66,281	90.00
91.00	09100	EMERGENCY	0	1,741,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-278,352	1,404,530	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	-8,144	1,148,014	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-173	285,526	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,754,226	49,147,739	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	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	8,913,383	192.01
192.02	19202	PHARMACARE	-6,127	4,383,175	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	13,490	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-3,760,353	62,457,787	200.00

RECLASSIFICATIONS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/23/2017 4:56 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	350,420	349,850	1.00
	0		350,420	349,850	
	C - LABOR DELIVERY NURSERY				
1.00	NURSERY	43.00	172,934	94,167	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	342,194	186,334	2.00
	0		515,128	280,501	
	D - NORTH ANNEX RECLASS				
1.00	HOME HEALTH AGENCY	101.00	0	5,275	1.00
2.00	HOSPICE	116.00	0	571	2.00
3.00	DEKALB MEDICAL SERVICES	192.01	0	3,471	3.00
	0		0	9,317	
	E - REHABILITATION OFFICE RECLASS				
1.00	CARDIAC REHAB	66.01	46,273	5,844	1.00
	0		46,273	5,844	
	F - RADIOLOGY ADMIN RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	12,484	12,623	1.00
	0		12,484	12,623	
500.00	Grand Total: Increases		924,305	658,135	500.00

RECLASSIFICATIONS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/23/2017 4:56 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	350,420	349,850	0		1.00
	0		350,420	349,850			
	C - LABOR DELIVERY NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	515,128	280,501	0		1.00
2.00		0.00	0	0	0		2.00
	0		515,128	280,501			
	D - NORTH ANNEX RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,317	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	9,317			
	E - REHABILITATION OFFICE RECLASS						
1.00	PHYSICAL THERAPY	66.00	46,273	5,844	0		1.00
	0		46,273	5,844			
	F - RADIOLOGY ADMIN RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	12,484	12,623	0		1.00
	0		12,484	12,623			
500.00	Grand Total: Decreases		924,305	658,135			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2017 4:56 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	1,781,970	48,740	0	48,740	0	2.00
3.00	Buildings and Fixtures	60,294,655	772,528	0	772,528	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	24,276,380	0	0	0	35,147	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	86,746,123	821,268	0	821,268	35,147	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	86,746,123	821,268	0	821,268	35,147	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	1,830,710	0	2.00
3.00	Buildings and Fixtures	61,067,183	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	24,241,233	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	87,532,244	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	87,532,244	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2017 4:56 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	4,958,324	0	383,778	0	0	1.00
1.01	MAC WEST - NEW	23,501	0	0	0	0	1.01
1.02	NORTH ANNEX - NEW	4,584	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	150,192	0	0	0	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	43,183	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)	5,208,285	0	383,778	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	5,342,102	1.00
1.01	MAC WEST - NEW	0	23,501	1.01
1.02	NORTH ANNEX - NEW	0	4,584	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	150,192	1.05
1.06	GARRETT LAB - NEW	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	43,183	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	5,592,063	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2017 4:56 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	63,291,011	0	63,291,011	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)	63,291,011	0	63,291,011	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	4,958,324	0	1.00
1.01	MAC WEST - NEW	0	0	0	23,501	0	1.01
1.02	NORTH ANNEX - NEW	0	0	0	4,584	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	150,192	0	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	43,183	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	5,208,285	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	0	0	0	0	4,958,324	1.00
1.01	MAC WEST - NEW	0	0	0	0	23,501	1.01
1.02	NORTH ANNEX - NEW	0	0	0	0	4,584	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	150,192	1.05
1.06	GARRETT LAB - NEW	0	0	0	0	0	1.06
1.07	MEDICAL ARTS - NEW	0	0	0	0	43,183	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	0	5,208,285	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/23/2017 4:56 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	-383,778	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	-971,571			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	-896	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-266,827	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	-201	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,140	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/23/2017 4:56 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	MISC HUMAN RESOURCE REVENUE	B	-16	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.04	MISCELLANEOUS INCOME	B	-167,204	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MISC. MAINTENANCE INCOME	B	-3,928	OPERATION OF PLANT	7.00	0	33.05
33.06	MISC. HOUSEKEEPING INCOME	B	-2,683	HOUSEKEEPING	9.00	0	33.06
33.07	DIABETES SERV. MISC. INCOME	B	-6,004	DIETARY	10.00	0	33.07
33.09	MISC SUGERY REVENUE	B	-2,955	OPERATING ROOM	50.00	0	33.09
33.10	MISC X-RAY REVENUE	B	-20,427	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	MISC LAB REVENUE	B	42	LABORATORY	60.00	0	33.11
33.12	MISC. PT REVENUE	B	-267	RESPIRATORY THERAPY	65.00	0	33.12
33.13	MISC. ST REVENUE	B	172	PHYSICAL THERAPY	66.00	0	33.13
33.14	MISC. CARDIAC REHAB REVENUE	B	-12,847	CARDIAC REHAB	66.01	0	33.14
33.15	EMS CLASS TUITION	B	-69,119	AMBULANCE SERVICES	95.00	0	33.15
33.16	EMS COUNTY SUBSIDY	B	-209,233	AMBULANCE SERVICES	95.00	0	33.16
33.17	MISCELLANEOUS INCOME	B	-7,627	HOME HEALTH AGENCY	101.00	0	33.17
33.18	LOBBYING PORTION OF IHA & AHA DUES	A	-6,626	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	LOBBYING PORTION OF IAHHC DUES - HOS	A	-118	HOSPICE	116.00	0	33.19
33.20	LOBBYING PORTION OF IAHHC DUES - HHA	A	-274	HOME HEALTH AGENCY	101.00	0	33.20
33.21	NON-ALLOWABLE MARKETING	A	-442,897	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.23	NON-ALLOWABLE MARKETING	A	-24,826	PHYSICAL THERAPY	66.00	0	33.23
33.25	NON-ALLOWABLE MARKETING	A	-402	CARDIAC REHAB	66.01	0	33.25
33.26	NON-ALLOWABLE MARKETING	A	-243	HOME HEALTH AGENCY	101.00	0	33.26
33.27	NON-ALLOWABLE MARKETING	A	-55	HOSPICE	116.00	0	33.27
33.28	NON-ALLOWABLE MARKETING	A	-6,127	PHARMACARE	192.02	0	33.28
33.29	SNACK BAR	B	-51,998	SNACK BAR	10.01	0	33.29
33.30	FLOWER/GIFTS	A	-75	NURSING ADMINISTRATION	13.00	0	33.30
33.32	FLOWER/GIFTS	A	-7,127	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.34	CHRISTMAS PARTY & OPEN HOUSE	A	-1,569	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.34
33.39	PHYSICIAN RECRUITMENT	A	-10,000	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	HAF FEE	A	-820,315	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	DONATION EXPENSE	A	-261,192	ADMINISTRATIVE & GENERAL	5.00	0	33.41
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,760,353				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2017 4:56 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	35,188	35,188	0	271,900	0	1.00
2.00	50.00	OPERATING ROOM	798,537	798,537	0	239,400	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	15,000	0	15,000	211,500	124	3.00
4.00	31.00	INTENSIVE CARE UNIT	50,400	50,400	0	211,500	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	64,000	64,000	0	237,100	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	1,200	1,200	0	211,500	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	1,000	1,000	0	211,500	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	9,225	9,225	0	211,500	0	8.00
9.00	50.00	OPERATING ROOM	9,630	9,630	0	211,500	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			984,180	969,180	15,000		124	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	5.00	ADMINISTRATIVE & GENERAL	12,609	630	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			12,609	630	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	35,188		1.00
2.00	50.00	OPERATING ROOM	0	0	0	798,537		2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	12,609	2,391	2,391		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	50,400		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	64,000		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,200		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,000		7.00
8.00	31.00	INTENSIVE CARE UNIT	0	0	0	9,225		8.00
9.00	50.00	OPERATING ROOM	0	0	0	9,630		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	12,609	2,391	971,571		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 4:56 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	4,958,324	4,958,324				1.00
1.01	00101	MAC WEST - NEW	23,501	0	23,501			1.01
1.02	00102	NORTH ANNEX - NEW	4,584	0	0	4,584		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	150,192	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	43,183	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	671,597	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,751,568	622,411	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	2,148,558	1,938,845	5,172	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,153	28,868	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,177,712	46,156	0	0	0	9.00
10.00	01000	DIETARY	392,233	24,226	0	0	0	10.00
10.01	01001	SNACK BAR	7,017	0	0	0	0	10.01
11.00	01100	CAFETERIA	433,443	56,987	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	997,433	25,629	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	209,396	30,440	0	0	0	14.00
15.00	01500	PHARMACY	565,518	27,998	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	658,391	67,577	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	90,262	3,965	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,289,369	283,510	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,492,849	120,382	0	0	0	31.00
43.00	04300	NURSERY	268,125	21,567	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,722,034	428,940	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	528,528	333,558	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,001,380	225,217	0	0	0	54.00
60.00	06000	LABORATORY	3,549,226	101,281	0	0	3,468	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	679,538	26,402	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,407,087	126,112	0	0	0	66.00
66.01	06601	CARDIAC REHAB	171,382	66,368	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	77,172	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,054	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,750,867	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,121,414	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,029,577	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	66,281	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,741,220	186,073	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,404,530	42,481	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,148,014	0	0	2,595	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	285,526	0	0	281	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,147,739	4,834,993	5,172	2,876	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	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	8,913,383	123,331	18,329	1,708	13,119	192.01
192.02	19202	PHARMACARE	4,383,175	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	13,490	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)	62,457,787	4,958,324	23,501	4,584	16,587	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 4:56 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	150,192				1.05
1.06	00106	GARRETT LAB - NEW	0	0	0			1.06
1.07	00107	MEDICAL ARTS - NEW	0	0	0	43,183		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	20,112	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	44,640	0	3,424	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	305	0	0	0	9.00
10.00	01000	DIETARY	0	817	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	1,138	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	67,012	0	3,424	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	83,180	0	39,759	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	150,192	0	43,183	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 4:56 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	671,597				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	89,770	9,483,861	9,483,861		5.00
7.00	00700	OPERATION OF PLANT	0	14,279	4,154,918	743,851	4,898,769	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	401	52,422	9,385	37,804	8.00
9.00	00900	HOUSEKEEPING	0	16,937	1,241,110	222,195	62,849	9.00
10.00	01000	DIETARY	0	5,190	422,466	75,634	38,184	10.00
10.01	01001	SNACK BAR	0	570	7,587	1,358	0	10.01
11.00	01100	CAFETERIA	0	8,682	499,112	89,356	74,627	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,444	1,043,506	186,818	33,561	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,219	242,055	43,335	39,862	14.00
15.00	01500	PHARMACY	0	12,798	606,314	108,548	36,664	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,381	739,487	132,390	97,487	16.00
17.00	01700	SOCIAL SERVICE	0	1,779	96,006	17,188	5,193	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	59,160	3,632,039	650,240	371,266	30.00
31.00	03100	INTENSIVE CARE UNIT	0	24,018	1,637,249	293,115	157,644	31.00
43.00	04300	NURSERY	0	4,285	293,977	52,630	28,242	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	39,352	3,190,326	571,161	561,711	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,479	870,565	155,856	436,805	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,216	3,269,813	585,391	294,929	54.00
60.00	06000	LABORATORY	0	31,911	3,686,729	660,031	168,599	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	13,074	719,014	128,724	34,575	65.00
66.00	06600	PHYSICAL THERAPY	0	6,806	1,540,005	275,706	165,148	66.00
66.01	06601	CARDIAC REHAB	0	3,627	241,377	43,213	86,911	66.01
69.00	06900	ELECTROCARDIOLOGY	0	1,487	78,659	14,082	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,221	80,275	14,372	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,750,867	313,456	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,121,414	200,766	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,029,577	542,382	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,455	67,736	12,127	0	90.00
91.00	09100	EMERGENCY	0	31,812	1,959,105	350,737	243,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	28,627	1,475,638	264,182	55,630	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	18,440	1,169,049	209,294	87,766	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,980	287,787	51,522	9,499	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	504,400	48,690,045	7,019,045	3,128,625	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	155,890	9,359,770	1,675,661	1,770,144	192.01
192.02	19202	PHARMACARE	0	11,079	4,394,254	786,699	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	228	13,718	2,456	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	671,597	62,457,787	9,483,861	4,898,769	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 4:56 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	99,611					8.00
9.00	00900	HOUSEKEEPING	8,920	1,535,074				9.00
10.00	01000	DIETARY	672	12,216	549,172			10.00
10.01	01001	SNACK BAR	0	0	0	8,945		10.01
11.00	01100	CAFETERIA	0	23,876	0	8,945	695,916	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,737	0	0	21,756	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,753	0	0	5,359	14.00
15.00	01500	PHARMACY	0	11,730	0	0	11,818	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,189	0	0	25,695	16.00
17.00	01700	SOCIAL SERVICE	0	1,661	0	0	2,040	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,698	118,780	465,346	0	88,824	30.00
31.00	03100	INTENSIVE CARE UNIT	8,597	50,435	83,826	0	35,794	31.00
43.00	04300	NURSERY	0	9,036	0	0	6,719	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,038	179,710	0	0	52,991	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	139,748	0	0	13,318	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,619	94,357	0	0	57,510	54.00
60.00	06000	LABORATORY	0	53,940	0	0	53,790	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	11,062	0	0	19,177	65.00
66.00	06600	PHYSICAL THERAPY	1,989	52,836	0	0	11,118	66.00
66.01	06601	CARDIAC REHAB	399	27,806	0	0	6,719	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2,800	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	701	0	0	0	1,880	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	462	0	0	0	1,240	90.00
91.00	09100	EMERGENCY	17,863	77,958	0	0	45,712	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,826	17,798	0	0	49,951	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	28,079	0	0	27,475	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	61	3,039	0	0	2,060	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	97,845	968,746	549,172	8,945	543,746	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	1,766	566,328	0	0	135,453	192.01
192.02	19202	PHARMACARE	0	0	0	0	16,477	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	240	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)	99,611	1,535,074	549,172	8,945	695,916	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 4:56 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	1,296,378					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	24,292	367,656				14.00
15.00	01500	PHARMACY	0	0	775,074			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,026,248		16.00
17.00	01700	SOCIAL SERVICE	9,228	0	0	0	131,316	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	402,702	0	0	102,562	131,316	30.00
31.00	03100	INTENSIVE CARE UNIT	162,297	0	0	37,696	0	31.00
43.00	04300	NURSERY	30,508	0	0	6,517	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	240,309	0	0	144,806	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	60,367	0	0	12,895	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	190,970	0	54.00
60.00	06000	LABORATORY	21,307	0	0	146,341	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	35,985	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	40,134	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	3,084	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	10,134	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,778	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	367,656	0	71,660	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	775,074	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,636	0	0	1,235	0	90.00
91.00	09100	EMERGENCY	207,281	0	0	110,715	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	123,084	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	9,367	0	0	4,564	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,296,378	367,656	775,074	927,076	131,316	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	99,172	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)	1,296,378	367,656	775,074	1,026,248	131,316	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 4:56 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	5,991,773	0	5,991,773	30.00
31.00	03100	INTENSIVE CARE UNIT	2,466,653	0	2,466,653	31.00
43.00	04300	NURSERY	427,629	0	427,629	43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,955,052	0	4,955,052	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,689,554	0	1,689,554	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,504,589	0	4,504,589	54.00
60.00	06000	LABORATORY	4,790,737	0	4,790,737	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	948,537	0	948,537	65.00
66.00	06600	PHYSICAL THERAPY	2,086,936	0	2,086,936	66.00
66.01	06601	CARDIAC REHAB	409,509	0	409,509	66.01
69.00	06900	ELECTROCARDIOLOGY	105,675	0	105,675	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	105,006	0	105,006	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,503,639	0	2,503,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,322,180	0	1,322,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,347,033	0	4,347,033	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	88,436	0	88,436	90.00
91.00	09100	EMERGENCY	3,013,040	0	3,013,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,867,025	0	1,867,025	95.00
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,644,747	0	1,644,747	101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	367,899	0	367,899	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,635,649	0	43,635,649	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	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	13,608,294	0	13,608,294	192.01
192.02	19202	PHARMACARE	5,197,430	0	5,197,430	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	16,414	0	16,414	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)	62,457,787	0	62,457,787	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/23/2017 4:56 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	622,411	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	1,938,845	5,172	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,868	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	46,156	0	0	0	9.00
10.00	01000	DIETARY	0	24,226	0	0	0	10.00
10.01	01001	SNACK BAR	0	0	0	0	0	10.01
11.00	01100	CAFETERIA	0	56,987	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,629	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,440	0	0	0	14.00
15.00	01500	PHARMACY	0	27,998	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67,577	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	3,965	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	283,510	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	120,382	0	0	0	31.00
43.00	04300	NURSERY	0	21,567	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	428,940	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	333,558	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	225,217	0	0	0	54.00
60.00	06000	LABORATORY	0	101,281	0	0	3,468	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	26,402	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	126,112	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	66,368	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	186,073	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	42,481	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	2,595	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	281	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,834,993	5,172	2,876	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	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	123,331	18,329	1,708	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	4,958,324	23,501	4,584	16,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/23/2017 4:56 pm

			CAPITAL RELATED COSTS					
		Cost Center Description	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	20,112	0	0	0	5.00
7.00	00700	OPERATION OF PLANT	0	44,640	0	3,424	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	305	0	0	0	9.00
10.00	01000	DIETARY	0	817	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	1,138	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	67,012	0	3,424	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	83,180	0	39,759	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	150,192	0	43,183	0	202.00

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		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	642,523	0	642,523		5.00
7.00	00700	OPERATION OF PLANT	0	1,992,081	0	50,395	2,042,476	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	28,868	0	636	15,762	8.00
9.00	00900	HOUSEKEEPING	0	46,461	0	15,053	26,204	9.00
10.00	01000	DIETARY	0	25,043	0	5,124	15,920	10.00
10.01	01001	SNACK BAR	0	0	0	92	0	10.01
11.00	01100	CAFETERIA	0	56,987	0	6,054	31,115	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,629	0	12,657	13,993	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,440	0	2,936	16,620	14.00
15.00	01500	PHARMACY	0	27,998	0	7,354	15,287	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	68,715	0	8,969	40,646	16.00
17.00	01700	SOCIAL SERVICE	0	3,965	0	1,164	2,165	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	283,510	0	44,053	154,794	30.00
31.00	03100	INTENSIVE CARE UNIT	0	120,382	0	19,858	65,727	31.00
43.00	04300	NURSERY	0	21,567	0	3,566	11,775	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	428,940	0	38,695	234,198	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	333,558	0	10,559	182,120	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	225,217	0	39,660	122,967	54.00
60.00	06000	LABORATORY	0	105,592	0	44,716	70,295	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	26,402	0	8,721	14,415	65.00
66.00	06600	PHYSICAL THERAPY	0	126,112	0	18,679	68,856	66.00
66.01	06601	CARDIAC REHAB	0	66,368	0	2,928	36,237	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	954	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	974	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	21,236	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,602	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,746	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	822	0	90.00
91.00	09100	EMERGENCY	0	186,073	0	23,762	101,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	42,481	0	17,898	23,194	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	2,595	0	14,179	36,593	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	281	0	3,491	3,960	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,917,788	0	475,533	1,304,437	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	290,497	0	113,526	738,039	192.01
192.02	19202	PHARMACARE	0	0	0	53,298	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	166	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	5,208,285	0	642,523	2,042,476	202.00

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		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	45,266					8.00
9.00	00900	HOUSEKEEPING	4,053	91,771				9.00
10.00	01000	DIETARY	305	730	47,122			10.00
10.01	01001	SNACK BAR	0	0	0	92		10.01
11.00	01100	CAFETERIA	0	1,427	0	92	95,675	11.00
13.00	01300	NURSING ADMINISTRATION	0	642	0	0	2,991	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	762	0	0	737	14.00
15.00	01500	PHARMACY	0	701	0	0	1,625	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,865	0	0	3,533	16.00
17.00	01700	SOCIAL SERVICE	0	99	0	0	280	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,041	7,101	39,929	0	12,212	30.00
31.00	03100	INTENSIVE CARE UNIT	3,907	3,015	7,193	0	4,921	31.00
43.00	04300	NURSERY	0	540	0	0	924	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,379	10,744	0	0	7,285	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,355	0	0	1,831	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,280	5,641	0	0	7,906	54.00
60.00	06000	LABORATORY	0	3,225	0	0	7,395	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	661	0	0	2,636	65.00
66.00	06600	PHYSICAL THERAPY	904	3,159	0	0	1,529	66.00
66.01	06601	CARDIAC REHAB	181	1,662	0	0	924	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	385	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	319	0	0	0	258	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	210	0	0	0	170	90.00
91.00	09100	EMERGENCY	8,118	4,661	0	0	6,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,738	1,064	0	0	6,867	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,679	0	0	3,777	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	28	182	0	0	283	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,463	57,915	47,122	92	74,753	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	803	33,856	0	0	18,624	192.01
192.02	19202	PHARMACARE	0	0	0	0	2,265	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	33	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)	45,266	91,771	47,122	92	95,675	202.00

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		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MAC WEST - NEW						1.01
1.02	00102	NORTH ANNEX - NEW						1.02
1.03	00103	GARRETT CLINIC - NEW						1.03
1.04	00104	BUTLER - NEW						1.04
1.05	00105	MAC EAST - NEW						1.05
1.06	00106	GARRETT LAB - NEW						1.06
1.07	00107	MEDICAL ARTS - NEW						1.07
1.08	00108	DAY SPRING - NEW						1.08
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
10.01	01001	SNACK BAR						10.01
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	55,912					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,048	52,543				14.00
15.00	01500	PHARMACY	0	0	52,965			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	123,728		16.00
17.00	01700	SOCIAL SERVICE	398	0	0	0	8,071	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,367	0	0	12,359	8,071	30.00
31.00	03100	INTENSIVE CARE UNIT	7,000	0	0	4,542	0	31.00
43.00	04300	NURSERY	1,316	0	0	785	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,364	0	0	17,449	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,604	0	0	1,554	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	23,078	0	54.00
60.00	06000	LABORATORY	919	0	0	17,634	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,336	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,836	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	372	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,221	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	937	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	52,543	0	8,635	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	52,965	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	243	0	0	149	0	90.00
91.00	09100	EMERGENCY	8,940	0	0	13,341	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	5,309	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	404	0	0	550	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,912	52,543	52,965	111,778	8,071	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	0	0	0	11,950	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)	55,912	52,543	52,965	123,728	8,071	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/23/2017 4:56 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	592,437	0	592,437		30.00
31.00	03100	INTENSIVE CARE UNIT	236,545	0	236,545		31.00
43.00	04300	NURSERY	40,473	0	40,473		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	754,054	0	754,054		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	540,581	0	540,581		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,749	0	429,749		54.00
60.00	06000	LABORATORY	249,776	0	249,776		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	57,171	0	57,171		65.00
66.00	06600	PHYSICAL THERAPY	224,075	0	224,075		66.00
66.01	06601	CARDIAC REHAB	108,672	0	108,672		66.01
69.00	06900	ELECTROCARDIOLOGY	2,560	0	2,560		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,488	0	2,488		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	82,414	0	82,414		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,602	0	13,602		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,711	0	89,711		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,594	0	1,594		90.00
91.00	09100	EMERGENCY	352,773	0	352,773		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	93,242	0	93,242		95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	64,132	0	64,132		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	9,179	0	9,179		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,945,228	0	3,945,228		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	0	0	0		192.00
192.01	19201	DEKALB MEDICAL SERVICES	1,207,295	0	1,207,295		192.01
192.02	19202	PHARMACARE	55,563	0	55,563		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	199	0	199		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)	5,208,285	0	5,208,285		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 4:56 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	3,595	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	0	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	0	0	0	0	192.00
192.01	19201	DEKALB MEDICAL SERVICES	5,101	12,739	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)	4,958,324	23,501	4,584	16,587	11,914	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.177865	1.438778	0.936275	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 4:56 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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 4:56 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)	150,192	0	43,183	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.007150	0.000000	5.035918	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: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet B-1 Date/Time Prepared: 2/23/2017 4:56 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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 4:56 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	27,105,946					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,623,118	-9,483,861	52,973,926			5.00
7.00	00700	OPERATION OF PLANT	576,302	0	4,154,918	154,722		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,181	0	52,422	1,194	303,942	8.00
9.00	00900	HOUSEKEEPING	683,583	0	1,241,110	1,985	27,217	9.00
10.00	01000	DIETARY	209,458	0	422,466	1,206	2,049	10.00
10.01	01001	SNACK BAR	22,994	0	7,587	0	0	10.01
11.00	01100	CAFETERIA	350,420	0	499,112	2,357	0	11.00
13.00	01300	NURSING ADMINISTRATION	825,105	0	1,043,506	1,060	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,571	0	242,055	1,259	0	14.00
15.00	01500	PHARMACY	516,534	0	606,314	1,158	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	499,678	0	739,487	3,079	0	16.00
17.00	01700	SOCIAL SERVICE	71,811	0	96,006	164	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,387,682	0	3,632,039	11,726	87,566	30.00
31.00	03100	INTENSIVE CARE UNIT	969,366	0	1,637,249	4,979	26,233	31.00
43.00	04300	NURSERY	172,934	0	293,977	892	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,588,250	0	3,190,326	17,741	42,834	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	342,194	0	870,565	13,796	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,744,181	0	3,269,813	9,315	35,454	54.00
60.00	06000	LABORATORY	1,287,928	0	3,686,729	5,325	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	527,684	0	719,014	1,092	0	65.00
66.00	06600	PHYSICAL THERAPY	274,702	0	1,540,005	5,216	6,069	66.00
66.01	06601	CARDIAC REHAB	146,389	0	241,377	2,745	1,216	66.01
69.00	06900	ELECTROCARDIOLOGY	60,018	0	78,659	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,294	0	80,275	0	2,139	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	1,750,867	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,121,414	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,029,577	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	58,723	0	67,736	0	1,411	90.00
91.00	09100	EMERGENCY	1,283,950	0	1,959,105	7,696	54,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,155,404	0	1,475,638	1,757	11,673	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	744,256	0	1,169,049	2,772	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	79,924	0	287,787	300	186	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,357,634	-9,483,861	39,206,184	98,814	298,553	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	6,291,947	0	9,359,770	55,908	5,389	192.01
192.02	19202	PHARMACARE	447,163	0	4,394,254	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	9,202	0	13,718	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)	671,597		9,483,861	4,898,769	99,611	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.024777		0.179029	31.661748	0.327730	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		642,523	2,042,476	45,266	204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet B-1 Date/Time Prepared: 2/23/2017 4:56 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		0.012129	13.200941	0.148930	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 4:56 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	151,543					9.00
10.00	01000	DIETARY	1,206	29,717				10.00
10.01	01001	SNACK BAR	0	0	100			10.01
11.00	01100	CAFETERIA	2,357	0	100	34,802		11.00
13.00	01300	NURSING ADMINISTRATION	1,060	0	0	1,088	297,406	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,259	0	0	268	5,573	14.00
15.00	01500	PHARMACY	1,158	0	0	591	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,079	0	0	1,285	0	16.00
17.00	01700	SOCIAL SERVICE	164	0	0	102	2,117	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,726	25,181	0	4,442	92,385	30.00
31.00	03100	INTENSIVE CARE UNIT	4,979	4,536	0	1,790	37,233	31.00
43.00	04300	NURSERY	892	0	0	336	6,999	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,741	0	0	2,650	55,130	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,796	0	0	666	13,849	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,315	0	0	2,876	0	54.00
60.00	06000	LABORATORY	5,325	0	0	2,690	4,888	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,092	0	0	959	0	65.00
66.00	06600	PHYSICAL THERAPY	5,216	0	0	556	0	66.00
66.01	06601	CARDIAC REHAB	2,745	0	0	336	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	140	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	94	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	62	1,293	90.00
91.00	09100	EMERGENCY	7,696	0	0	2,286	47,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,757	0	0	2,498	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,772	0	0	1,374	28,237	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	300	0	0	103	2,149	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,635	29,717	100	27,192	297,406	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	55,908	0	0	6,774	0	192.01
192.02	19202	PHARMACARE	0	0	0	824	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	12	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)	1,535,074	549,172	8,945	695,916	1,296,378	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.129627	18.480062	89.450000	19.996437	4.358950	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	91,771	47,122	92	95,675	55,912	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 4:56 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)	0.605577	1.585692	0.920000	2.749124	0.187999	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 4:56 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	140,520,687			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	14,043,861	100		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,161,775	0		31.00
43.00	04300	NURSERY	0	0	892,349	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	19,828,301	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,765,740	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	26,146,010	0		54.00
60.00	06000	LABORATORY	0	0	20,038,458	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
65.00	06500	RESPIRATORY THERAPY	0	0	4,927,417	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	5,495,553	0		66.00
66.01	06601	CARDIAC REHAB	0	0	422,242	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	1,387,710	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	1,064,996	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	100	0	9,812,474	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	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	169,118	0		90.00
91.00	09100	EMERGENCY	0	0	15,160,217	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	624,902	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	126,941,123	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	13,579,564	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)	367,656	775,074	1,026,248	131,316		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,676.560000	7,750.740000	0.007303	1,313.160000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,543	52,965	123,728	8,071		204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet B-1 Date/Time Prepared: 2/23/2017 4:56 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)	525.430000	529.650000	0.000880	80.710000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 4:56 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,991,773		5,991,773	0	5,991,773	30.00
31.00	03100	INTENSIVE CARE UNIT	2,466,653		2,466,653	0	2,466,653	31.00
43.00	04300	NURSERY	427,629		427,629	0	427,629	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,955,052		4,955,052	0	4,955,052	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,689,554		1,689,554	0	1,689,554	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,504,589		4,504,589	0	4,504,589	54.00
60.00	06000	LABORATORY	4,790,737		4,790,737	0	4,790,737	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	948,537	0	948,537	0	948,537	65.00
66.00	06600	PHYSICAL THERAPY	2,086,936	0	2,086,936	0	2,086,936	66.00
66.01	06601	CARDIAC REHAB	409,509	0	409,509	0	409,509	66.01
69.00	06900	ELECTROCARDIOLOGY	105,675		105,675	0	105,675	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	105,006		105,006	0	105,006	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,503,639		2,503,639	0	2,503,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,322,180		1,322,180	0	1,322,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,347,033		4,347,033	0	4,347,033	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,436		88,436	0	88,436	90.00
91.00	09100	EMERGENCY	3,013,040		3,013,040	0	3,013,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,389,416		1,389,416		1,389,416	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,867,025		1,867,025	0	1,867,025	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,644,747		1,644,747		1,644,747	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	367,899		367,899		367,899	116.00
200.00		Subtotal (see instructions)	45,025,065	0	45,025,065	0	45,025,065	200.00
201.00		Less Observation Beds	1,389,416		1,389,416		1,389,416	201.00
202.00		Total (see instructions)	43,635,649	0	43,635,649	0	43,635,649	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I | Date/Time Prepared: 2/23/2017 4:56 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	10,922,874		10,922,874			30.00
31.00	03100	INTENSIVE CARE UNIT	4,697,421		4,697,421			31.00
43.00	04300	NURSERY	874,272		874,272			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,177,194	15,409,312	19,586,506	0.252983	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,744,940	6,986	1,751,926	0.964398	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,801,634	24,004,702	25,806,336	0.174554	0.000000	54.00
60.00	06000	LABORATORY	3,371,815	19,902,633	23,274,448	0.205837	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,737,032	1,145,472	4,882,504	0.194273	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	911,895	4,515,261	5,427,156	0.384536	0.000000	66.00
66.01	06601	CARDIAC REHAB	3,938	412,677	416,615	0.982943	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	226,505	1,143,912	1,370,417	0.077112	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,050,748	1,050,748	0.099935	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,767,356	2,808,845	4,576,201	0.547100	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,495,947	1,670,935	5,166,882	0.255895	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,256,529	4,739,682	6,996,211	0.621341	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	130	166,726	166,856	0.530014	0.000000	90.00
91.00	09100	EMERGENCY	2,430,327	12,540,042	14,970,369	0.201267	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	3,428,447	3,428,447	0.405261	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,684,137	5,684,137	0.328462	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	1,167,558	1,167,558			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	42,168	582,734	624,902			116.00
200.00		Subtotal (see instructions)	42,461,977	100,380,809	142,842,786			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,461,977	100,380,809	142,842,786			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 4:56 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	0.252983	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964398	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174554	54.00
60.00	06000	LABORATORY	0.205837	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.194273	65.00
66.00	06600	PHYSICAL THERAPY	0.384536	66.00
66.01	06601	CARDIAC REHAB	0.982943	66.01
69.00	06900	ELECTROCARDIOLOGY	0.077112	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.099935	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.547100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255895	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.621341	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.530014	90.00
91.00	09100	EMERGENCY	0.201267	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.405261	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.328462	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 4:56 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	5,991,773		5,991,773	0	5,991,773	30.00
31.00	03100	INTENSIVE CARE UNIT	2,466,653		2,466,653	0	2,466,653	31.00
43.00	04300	NURSERY	427,629		427,629	0	427,629	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,955,052		4,955,052	0	4,955,052	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,689,554		1,689,554	0	1,689,554	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,504,589		4,504,589	0	4,504,589	54.00
60.00	06000	LABORATORY	4,790,737		4,790,737	0	4,790,737	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	948,537	0	948,537	0	948,537	65.00
66.00	06600	PHYSICAL THERAPY	2,086,936	0	2,086,936	0	2,086,936	66.00
66.01	06601	CARDIAC REHAB	409,509	0	409,509	0	409,509	66.01
69.00	06900	ELECTROCARDIOLOGY	105,675		105,675	0	105,675	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	105,006		105,006	0	105,006	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,503,639		2,503,639	0	2,503,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,322,180		1,322,180	0	1,322,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,347,033		4,347,033	0	4,347,033	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	88,436		88,436	0	88,436	90.00
91.00	09100	EMERGENCY	3,013,040		3,013,040	0	3,013,040	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1,389,416		1,389,416		1,389,416	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,867,025		1,867,025	0	1,867,025	95.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	1,644,747		1,644,747		1,644,747	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	367,899		367,899		367,899	116.00
200.00		Subtotal (see instructions)	45,025,065	0	45,025,065	0	45,025,065	200.00
201.00		Less Observation Beds	1,389,416		1,389,416		1,389,416	201.00
202.00		Total (see instructions)	43,635,649	0	43,635,649	0	43,635,649	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 4:56 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	10,922,874		10,922,874			30.00
31.00	03100	INTENSIVE CARE UNIT	4,697,421		4,697,421			31.00
43.00	04300	NURSERY	874,272		874,272			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,177,194	15,409,312	19,586,506	0.252983	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,744,940	6,986	1,751,926	0.964398	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,801,634	24,004,702	25,806,336	0.174554	0.000000	54.00
60.00	06000	LABORATORY	3,371,815	19,902,633	23,274,448	0.205837	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	3,737,032	1,145,472	4,882,504	0.194273	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	911,895	4,515,261	5,427,156	0.384536	0.000000	66.00
66.01	06601	CARDIAC REHAB	3,938	412,677	416,615	0.982943	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	226,505	1,143,912	1,370,417	0.077112	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,050,748	1,050,748	0.099935	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,767,356	2,808,845	4,576,201	0.547100	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,495,947	1,670,935	5,166,882	0.255895	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,256,529	4,739,682	6,996,211	0.621341	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	130	166,726	166,856	0.530014	0.000000	90.00
91.00	09100	EMERGENCY	2,430,327	12,540,042	14,970,369	0.201267	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	3,428,447	3,428,447	0.405261	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,684,137	5,684,137	0.328462	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	1,167,558	1,167,558			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	42,168	582,734	624,902			116.00
200.00		Subtotal (see instructions)	42,461,977	100,380,809	142,842,786			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	42,461,977	100,380,809	142,842,786			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 4:56 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: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet D Part I Date/Time Prepared: 2/23/2017 4:56 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	592,437	0	592,437	6,473	91.52	30.00
31.00	INTENSIVE CARE UNIT	236,545		236,545	1,490	158.76	31.00
43.00	NURSERY	40,473		40,473	860	47.06	43.00
200.00	Total (lines 30-199)	869,455		869,455	8,823		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	1,763	161,350	30.00
31.00	INTENSIVE CARE UNIT	461	73,188	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	2,224	234,538	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II | Date/Time Prepared: 2/23/2017 4:56 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	754,054	19,586,506	0.038499	1,096,080	42,198	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	540,581	1,751,926	0.308564	3,942	1,216	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	429,749	25,806,336	0.016653	1,325,625	22,076	54.00
60.00	06000	LABORATORY	249,776	23,274,448	0.010732	1,604,413	17,219	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	57,171	4,882,504	0.011709	1,483,887	17,375	65.00
66.00	06600	PHYSICAL THERAPY	224,075	5,427,156	0.041288	388,842	16,055	66.00
66.01	06601	CARDIAC REHAB	108,672	416,615	0.260845	722	188	66.01
69.00	06900	ELECTROCARDIOLOGY	2,560	1,370,417	0.001868	99,988	187	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,488	1,050,748	0.002368	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	82,414	4,576,201	0.018009	665,110	11,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,602	5,166,882	0.002633	993,898	2,617	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,711	6,996,211	0.012823	907,830	11,641	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,594	166,856	0.009553	0	0	90.00
91.00	09100	EMERGENCY	352,773	14,970,369	0.023565	956,330	22,536	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	137,379	3,428,447	0.040070	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,046,599	118,871,622		9,526,667	165,286	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/23/2017 4:56 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	6,473	0.00	1,763	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,490	0.00	461	0	31.00
43.00	04300	NURSERY	860	0.00	0	0	43.00
200.00		Total (lines 30-199)	8,823		2,224	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/23/2017 4:56 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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 4:56 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	19,586,506	0.000000	0.000000	1,096,080	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,751,926	0.000000	0.000000	3,942	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,806,336	0.000000	0.000000	1,325,625	54.00
60.00	06000	LABORATORY	0	23,274,448	0.000000	0.000000	1,604,413	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	4,882,504	0.000000	0.000000	1,483,887	65.00
66.00	06600	PHYSICAL THERAPY	0	5,427,156	0.000000	0.000000	388,842	66.00
66.01	06601	CARDIAC REHAB	0	416,615	0.000000	0.000000	722	66.01
69.00	06900	ELECTROCARDIOLOGY	0	1,370,417	0.000000	0.000000	99,988	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,050,748	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	4,576,201	0.000000	0.000000	665,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,166,882	0.000000	0.000000	993,898	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,996,211	0.000000	0.000000	907,830	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	166,856	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	14,970,369	0.000000	0.000000	956,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	3,428,447	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	118,871,622			9,526,667	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 4:56 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	2,769,432	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,561,173	0	54.00
60.00	06000	LABORATORY	0	1,825,680	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	192,193	0	65.00
66.00	06600	PHYSICAL THERAPY	0	24,752	0	66.00
66.01	06601	CARDIAC REHAB	0	165,640	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	276,503	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	227,070	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	352,543	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	178,251	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,295,446	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,988,267	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	800,360	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	14,657,310	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/23/2017 4:56 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	0.252983	2,769,432	0	0	700,619	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964398	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174554	4,561,173	0	0	796,171	54.00
60.00	06000	LABORATORY	0.205837	1,825,680	1,982	0	375,792	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.194273	192,193	0	0	37,338	65.00
66.00	06600	PHYSICAL THERAPY	0.384536	24,752	0	0	9,518	66.00
66.01	06601	CARDIAC REHAB	0.982943	165,640	0	0	162,815	66.01
69.00	06900	ELECTROCARDIOLOGY	0.077112	276,503	0	0	21,322	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.099935	227,070	0	0	22,692	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.547100	352,543	0	0	192,876	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255895	178,251	0	0	45,614	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.621341	1,295,446	0	20,692	804,914	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.530014	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.201267	1,988,267	0	0	400,173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.405261	800,360	0	0	324,355	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.328462		0			95.00
200.00		Subtotal (see instructions)		14,657,310	1,982	20,692	3,894,199	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		14,657,310	1,982	20,692	3,894,199	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/23/2017 4:56 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	408	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	12,857	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)	408	12,857	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	408	12,857	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/23/2017 4:56 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)	6,473	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,473	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)	4,972	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)	1,763	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)	5,991,773	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)	5,991,773	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)	5,991,773	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)	925.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,631,939	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)	1,631,939	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 4:56 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	2,466,653	1,490	1,655.47	461	763,172	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)	2,663,722	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,058,833	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)	234,538	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	165,286	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	399,824	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,659,009	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)	1,501	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	925.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,389,416	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/23/2017 4:56 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	592,437	5,991,773	0.098875	1,389,416	137,379	90.00
91.00	Nursing School cost	0	5,991,773	0.000000	1,389,416	0	91.00
92.00	Allied health cost	0	5,991,773	0.000000	1,389,416	0	92.00
93.00	All other Medical Education	0	5,991,773	0.000000	1,389,416	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/23/2017 4:56 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)	6,473	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,473	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)	4,972	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)	267	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)	860	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)	5,991,773	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)	5,991,773	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)	5,991,773	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)	925.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	247,151	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)	247,151	41.00

		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)	427,629	860	497.24	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,466,653	1,490	1,655.47	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)	213,415	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	460,566	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)	1,501	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	925.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,389,416	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 4:56 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	592,437	5,991,773	0.098875	1,389,416	137,379	90.00
91.00	Nursing School cost	0	5,991,773	0.000000	1,389,416	0	91.00
92.00	Allied health cost	0	5,991,773	0.000000	1,389,416	0	92.00
93.00	All other Medical Education	0	5,991,773	0.000000	1,389,416	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/23/2017 4:56 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		3,831,179		30.00
31.00	03100	INTENSIVE CARE UNIT		1,529,058		31.00
43.00	04300	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.252983	1,096,080	277,290	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964398	3,942	3,802	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174554	1,325,625	231,393	54.00
60.00	06000	LABORATORY	0.205837	1,604,413	330,248	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.194273	1,483,887	288,279	65.00
66.00	06600	PHYSICAL THERAPY	0.384536	388,842	149,524	66.00
66.01	06601	CARDIAC REHAB	0.982943	722	710	66.01
69.00	06900	ELECTROCARDIOLOGY	0.077112	99,988	7,710	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.099935	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.547100	665,110	363,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255895	993,898	254,334	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.621341	907,830	564,072	73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.530014	0	0	90.00
91.00	09100	EMERGENCY	0.201267	956,330	192,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.405261	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)		9,526,667	2,663,722	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)		9,526,667		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/23/2017 4:56 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		242,161		30.00
31.00	03100	INTENSIVE CARE UNIT		231,758		31.00
43.00	04300	NURSERY		302,371		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.252983	52,613	13,310	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.964398	45,914	44,279	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174554	38,287	6,683	54.00
60.00	06000	LABORATORY	0.205837	201,323	41,440	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.194273	178,362	34,651	65.00
66.00	06600	PHYSICAL THERAPY	0.384536	4,648	1,787	66.00
66.01	06601	CARDIAC REHAB	0.982943	89	87	66.01
69.00	06900	ELECTROCARDIOLOGY	0.077112	4,045	312	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.099935	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.547100	20,432	11,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.255895	8,147	2,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.621341	76,713	47,665	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.530014	0	0	90.00
91.00	09100	EMERGENCY	0.201267	49,378	9,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.405261	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)		679,951	213,415	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)		679,951		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Date/Time Prepared: 2/23/2017 4:56 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,438,370	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)	3,172	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)	51.90	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
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)	3.70	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.63	31.00
32.00	Sum of lines 30 and 31	25.33	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.11	33.00
34.00	Disproportionate share adjustment (see instructions)	86,905	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Date/Time Prepared: 2/23/2017 4:56 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000044238	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	283,395	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	283,395	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	283,395		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,811,842		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	3,811,842	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	272,115	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)	4,083,957	59.00
60.00	Primary payer payments	5,884	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	4,078,073	61.00
62.00	Deductibles billed to program beneficiaries	583,296	62.00
63.00	Coinsurance billed to program beneficiaries	20,881	63.00
64.00	Allowable bad debts (see instructions)	29,920	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	19,448	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,901	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	3,493,344	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	1,707	70.93
70.94	HRR adjustment amount (see instructions)	-6,189	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/23/2017 4:56 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	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)	2016	503,201	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)		3,992,063	71.00
71.01	Sequestration adjustment (see instructions)		79,841	71.01
72.00	Interim payments		3,964,105	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)		-51,883	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		150,304	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		1.0013070501	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 2/23/2017 4:56 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	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,438,370	0		3,438,370	3,438,370	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	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	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,172	0	0	3,172	3,172	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	0.1011	0.1011	0.1011	0.1011		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	86,905	0	0	86,905	86,905	11.00
11.01	Uncompensated care payments	36.00	283,395	0	0	283,395	283,395	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	3,811,842	0	0	3,811,842	3,811,842	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	3,811,842	0	0	3,811,842	3,811,842	15.00
16.00	Payment for inpatient program capital	50.00	272,115	0	0	272,115	272,115	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 4 | Date/Time Prepared: 2/23/2017 4:56 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	4,083,957	4,083,957	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	271,045	0	0	271,045	271,045	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,070	0	0	1,070	1,070	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	272,115	0	0	272,115	272,115	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	0.123214		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				503,201	503,201	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 5 | Date/Time Prepared: 2/23/2017 4:56 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	3,438,370		3,438,370	3,438,370	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	3,172	0	3,172	3,172	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	0.1011	0.1011	0.1011		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	86,905	0	86,905	86,905	11.00
11.01	Uncompensated care payments	36.00	283,395	0	0	0	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	3,811,842	0	3,811,842	3,811,842	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	3,811,842	0	3,811,842	3,811,842	15.00
16.00	Payment for inpatient program capital	50.00	272,115	0	272,115	272,115	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	4,083,957	4,083,957	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/23/2017 4:56 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	271,045	0	271,045	271,045	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	1,070	0	1,070	1,070	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	272,115	0	272,115	272,115	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	503,201		503,201	503,201	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	1,707	0	1,707	1,707	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	-6,189	0	-6,189	-6,189	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: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/23/2017 4:56 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	13,265	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,894,199	2.00
3.00	PPS payments	3,054,104	3.00
4.00	Outlier payment (see instructions)	8,268	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)	13,265	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	22,674	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)	22,674	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)	22,674	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	9,409	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)	13,265	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)	3,062,372	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)	685,536	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)	2,390,101	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)	2,390,101	30.00
31.00	Primary payer payments	69	31.00
32.00	Subtotal (line 30 minus line 31)	2,390,032	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)	126,218	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	82,042	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	119,242	36.00
37.00	Subtotal (see instructions)	2,472,074	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,472,074	40.00
40.01	Sequestration adjustment (see instructions)	49,441	40.01
41.00	Interim payments	2,335,210	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	87,423	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 2/23/2017 4:56 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,964,105		2,335,210	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,964,105		2,335,210	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		87,423	6.01
6.02	SETTLEMENT TO PROGRAM		51,883		0	6.02
7.00	Total Medicare program liability (see instructions)		3,912,222		2,422,633	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: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/23/2017 4:56 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	2,179	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,224	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,523	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	6,462	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	142,842,786	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	904,000	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)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-3 Part VII Date/Time Prepared: 2/23/2017 4:56 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	460,566		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)	460,566	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)	460,566	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	776,290		8.00
9.00	Ancillary service charges	679,951	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)	1,456,241	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)	1,456,241	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	995,675	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)	460,566	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)	460,566	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)	460,566	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)	460,566	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	460,566	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)	460,566	0	40.00
41.00	Interim payments	585,273	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-124,707	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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/23/2017 4:56 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	1,049,131	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,040,649	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,267,616	0	0	0	7.00
8.00	Prepaid expenses	610,417	0	0	0	8.00
9.00	Other current assets	85,646	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)	11,053,459	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	393,118	0	0	0	12.00
13.00	Land improvements	1,830,710	0	0	0	13.00
14.00	Accumulated depreciation	-1,493,612	0	0	0	14.00
15.00	Buildings	61,067,184	0	0	0	15.00
16.00	Accumulated depreciation	-29,938,340	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-67,788	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	-248,828	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	24,241,233	0	0	0	23.00
24.00	Accumulated depreciation	-16,694,886	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	-397,333	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)	38,691,458	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	15,957,764	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	68,074	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,025,838	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	65,770,755	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,338,780	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,712,938	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,122,785	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	1,221,698	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,396,201	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,090,827	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	680,509	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,771,336	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,167,537	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	48,603,218				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)	48,603,218	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,770,755	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 Date/Time Prepared: 2/23/2017 4:56 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		47,294,299		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,308,919				2.00
3.00	Total (sum of line 1 and line 2)		48,603,218		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		48,603,218		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		48,603,218		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	Additions (credit adjustments) (specify)		0		4.00
5.00			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	Deductions (debit adjustments) (specify)		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: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2017 4:56 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,797,146		11,797,146	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)	11,797,146		11,797,146	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,697,421		4,697,421	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)	4,697,421		4,697,421	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,494,567		16,494,567	17.00
18.00	Ancillary services	23,494,786	76,811,166	100,305,952	18.00
19.00	Outpatient services	2,430,457	16,135,215	18,565,672	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		1,167,558	1,167,558	22.00
23.00	AMBULANCE SERVICES	0	5,684,137	5,684,137	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	42,168	582,734	624,902	26.00
27.00	DIETARY	0	22,915	22,915	27.00
27.01	DHMG PHYSICIANS	0	13,579,564	13,579,564	27.01
27.02	SELF-INSURANCE	334,197	1,259,173	1,593,370	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	42,796,175	115,242,462	158,038,637	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		66,218,140		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)		66,218,140		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0045 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/23/2017 4:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	158,038,637	1.00
2.00	Less contractual allowances and discounts on patients' accounts	99,241,579	2.00
3.00	Net patient revenues (line 1 minus line 2)	58,797,058	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	66,218,140	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,421,082	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	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	6,944,788	24.00
24.01	OTHER NON-OPERATING INCOME	1,785,214	24.01
25.00	Total other income (sum of lines 6-24)	8,730,002	25.00
26.00	Total (line 5 plus line 25)	1,308,920	26.00
27.00	ROUNDING	1	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,308,919	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H | Date/Time Prepared: 2/23/2017 4:56 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	155,628	318,593	38,504	40,971	8,559	562,255	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	305,865	0	0	0	0	305,865	6.00
7.00	Physical Therapy	98,969	0	0	0	0	98,969	7.00
8.00	Occupational Therapy	39,837	0	0	0	0	39,837	8.00
9.00	Speech Pathology	889	0	0	0	0	889	9.00
10.00	Medical Social Services	15,835	0	0	0	0	15,835	10.00
11.00	Home Health Aide	127,233	0	0	0	0	127,233	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
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	744,256	318,593	38,504	40,971	8,559	1,150,883	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	5,275	567,530	-8,144	559,386	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	305,865	0	305,865	6.00
7.00	Physical Therapy	0	98,969	0	98,969	7.00
8.00	Occupational Therapy	0	39,837	0	39,837	8.00
9.00	Speech Pathology	0	889	0	889	9.00
10.00	Medical Social Services	0	15,835	0	15,835	10.00
11.00	Home Health Aide	0	127,233	0	127,233	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
23.50	Telemedicine	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	5,275	1,156,158	-8,144	1,148,014	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: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part I | Date/Time Prepared: 2/23/2017 4:56 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		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	559,386	0	0	0	0	559,386	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	305,865	0	0	0	0	305,865	6.00
7.00	Physical Therapy	98,969	0	0	0	0	98,969	7.00
8.00	Occupational Therapy	39,837	0	0	0	0	39,837	8.00
9.00	Speech Pathology	889	0	0	0	0	889	9.00
10.00	Medical Social Services	15,835	0	0	0	0	15,835	10.00
11.00	Home Health Aide	127,233	0	0	0	0	127,233	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
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,148,014	0	0	0	0	1,148,014	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	559,386		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	290,671	596,536	6.00
7.00	Physical Therapy	94,052	193,021	7.00
8.00	Occupational Therapy	37,858	77,695	8.00
9.00	Speech Pathology	845	1,734	9.00
10.00	Medical Social Services	15,048	30,883	10.00
11.00	Home Health Aide	120,912	248,145	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
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,148,014	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part II | Date/Time Prepared: 2/23/2017 4:56 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-559,386	588,628	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	305,865	6.00
7.00	Physical Therapy	0	0	0	0	0	98,969	7.00
8.00	Occupational Therapy	0	0	0	0	0	39,837	8.00
9.00	Speech Pathology	0	0	0	0	0	889	9.00
10.00	Medical Social Services	0	0	0	0	0	15,835	10.00
11.00	Home Health Aide	0	0	0	0	0	127,233	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
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-559,386	588,628	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		559,386	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.950322	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-0045
HHA CCN: 15-7157

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

Worksheet H-2
Part I
Date/Time Prepared:
2/23/2017 4:56 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	2,595	0	0	1.00
2.00	Skilled Nursing Care	596,536	0	0	0	0	0	2.00
3.00	Physical Therapy	193,021	0	0	0	0	0	3.00
4.00	Occupational Therapy	77,695	0	0	0	0	0	4.00
5.00	Speech Pathology	1,734	0	0	0	0	0	5.00
6.00	Medical Social Services	30,883	0	0	0	0	0	6.00
7.00	Home Health Aide	248,145	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,148,014	0	0	2,595	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	18,440	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	18,440	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: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 2/23/2017 4:56 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	21,035	3,766	87,766	0	28,079	0	1.00
2.00	Skilled Nursing Care	596,536	106,798	0	0	0	0	2.00
3.00	Physical Therapy	193,021	34,556	0	0	0	0	3.00
4.00	Occupational Therapy	77,695	13,910	0	0	0	0	4.00
5.00	Speech Pathology	1,734	310	0	0	0	0	5.00
6.00	Medical Social Services	30,883	5,529	0	0	0	0	6.00
7.00	Home Health Aide	248,145	44,425	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,169,049	209,294	87,766	0	28,079	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	27,475	123,084	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	27,475	123,084	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: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 2/23/2017 4:56 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	291,205	0	291,205			1.00
2.00	Skilled Nursing Care	0	703,334	0	703,334	151,317	854,651	2.00
3.00	Physical Therapy	0	227,577	0	227,577	48,962	276,539	3.00
4.00	Occupational Therapy	0	91,605	0	91,605	19,708	111,313	4.00
5.00	Speech Pathology	0	2,044	0	2,044	440	2,484	5.00
6.00	Medical Social Services	0	36,412	0	36,412	7,834	44,246	6.00
7.00	Home Health Aide	0	292,570	0	292,570	62,944	355,514	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	1,644,747	0	1,644,747	291,205	1,644,747	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.					0.215143		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: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part II | Date/Time Prepared: 2/23/2017 4:56 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
19.50	Telemedicine	0	0	0	0	0	0	19.50
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	2,595	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.936147	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	744,256	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	744,256		20.00
21.00	Total cost to be allocated	0	0	0	0	18,440		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.024776		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-0045 | HHA CCN: 15-7157

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

Worksheet H-2 Part II | Date/Time Prepared: 2/23/2017 4:56 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	21,035	2,772	0	2,772	0	0	1.00
2.00	Skilled Nursing Care	596,536	0	0	0	0	0	2.00
3.00	Physical Therapy	193,021	0	0	0	0	0	3.00
4.00	Occupational Therapy	77,695	0	0	0	0	0	4.00
5.00	Speech Pathology	1,734	0	0	0	0	0	5.00
6.00	Medical Social Services	30,883	0	0	0	0	0	6.00
7.00	Home Health Aide	248,145	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,169,049	2,772	0	2,772	0	0	20.00
21.00	Total cost to be allocated	209,294	87,766	0	28,079	0	0	21.00
22.00	Unit cost multiplier	0.179029	31.661616	0.000000	10.129509	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	1,374	28,237	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,374	28,237	0	0	0	0	20.00
21.00	Total cost to be allocated	27,475	123,084	0	0	0	0	21.00
22.00	Unit cost multiplier	19.996361	4.358962	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 2/23/2017 4:56 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	854,651		854,651	4,591	186.16	1.00
2.00	Physical Therapy	3.00	276,539	0	276,539	1,735	159.39	2.00
3.00	Occupational Therapy	4.00	111,313	0	111,313	313	355.63	3.00
4.00	Speech Pathology	5.00	2,484	0	2,484	82	30.29	4.00
5.00	Medical Social Services	6.00	44,246		44,246	26	1,701.77	5.00
6.00	Home Health Aide	7.00	355,514		355,514	2,277	156.13	6.00
7.00	Total (sum of lines 1-6)		1,644,747	0	1,644,747	9,024		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		50031	0	432			8.00
8.01	Skilled Nursing Care		99915	0	1,322			8.01
9.00	Physical Therapy		50031	0	167			9.00
9.01	Physical Therapy		99915	0	556			9.01
10.00	Occupational Therapy		50031	0	3			10.00
10.01	Occupational Therapy		99915	0	114			10.01
11.00	Speech Pathology		50031	0	14			11.00
11.01	Speech Pathology		99915	0	12			11.01
12.00	Medical Social Services		50031	0	4			12.00
12.01	Medical Social Services		99915	0	6			12.01
13.00	Home Health Aide		50031	0	110			13.00
13.01	Home Health Aide		99915	0	427			13.01
14.00	Total (sum of lines 8-13)			0	3,167			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	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	1,754		0	326,525		1.00
2.00	Physical Therapy	0	723		0	115,239		2.00
3.00	Occupational Therapy	0	117		0	41,609		3.00
4.00	Speech Pathology	0	26		0	788		4.00
5.00	Medical Social Services	0	10		0	17,018		5.00
6.00	Home Health Aide	0	537		0	83,842		6.00
7.00	Total (sum of lines 1-6)	0	3,167		0	585,021		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 2/23/2017 4:56 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	326,525	1.00
2.00	Physical Therapy	115,239	2.00
3.00	Occupational Therapy	41,609	3.00
4.00	Speech Pathology	788	4.00
5.00	Medical Social Services	17,018	5.00
6.00	Home Health Aide	83,842	6.00
7.00	Total (sum of lines 1-6)	585,021	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: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part II | Date/Time Prepared: 2/23/2017 4:56 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	0.384536	0	0	col. 2, line 2.00	1.00
1.01	Physical Therapy 1	66.01	0.982943	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	0.547100	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.621341	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 15-0045 | HHA CCN: 15-7157 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/23/2017 4:56 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	428,165	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	8,541	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	10,912	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,397	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	1,162	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	452,177	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	452,177	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	452,177	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	452,177	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	452,177	31.00
31.01	Sequestration adjustment (see instructions)	0	9,044	31.01
32.00	Interim payments (see instructions)	0	443,134	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	-1	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-0045 HHA CCN: 15-7157	Period: From 10/01/2015 To 09/30/2016	Worksheet H-5 Date/Time Prepared: 2/23/2017 4:56 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		443,134	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		443,134	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		0		443,133	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	12,719	12,719	0	12,719	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	179,006	179,006	571	179,577	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	617	617	0	617	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	3,628	3,628	0	3,628	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	9,234	9,234	0	9,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	5,261	0	5,261	0	5,261	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	62,806	0	62,806	0	62,806	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	140	0	140	0	140	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	149	0	149	0	149	33.00
34.00	SPIRITUAL COUNSELING**	5,157	0	5,157	0	5,157	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	6,058	0	6,058	0	6,058	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	353	0	353	0	353	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	79,924	205,204	285,128	571	285,699	100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	12,719	3.00
4.00	ADMINISTRATIVE & GENERAL*	-173	179,404	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	617	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	3,628	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	9,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	5,261	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	62,806	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	140	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	149	33.00
34.00	SPIRITUAL COUNSELING**	0	5,157	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	6,058	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	353	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
	NONREIMBURSABLE COST CENTERS			
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	-173	285,526	100.00

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

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

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-2 | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	5,165	0	5,165	0	5,165	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	61,669	0	61,669	0	61,669	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	5,063	0	5,063	0	5,063	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	5,948	0	5,948	0	5,948	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	77,845	0	77,845	0	77,845	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	5,165	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	61,669	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	5,063	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	5,948	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	77,845	100.00

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

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

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-3 | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	8	0	8	0	8	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	92	0	92	0	92	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	8	0	8	0	8	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	9	0	9	0	9	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	117	0	117	0	117	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	8	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	92	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	8	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	9	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	117	100.00

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

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

Provider CCN: 15-0045 | Hospice CCN: 15-1559

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

Worksheet O-4

Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	88	0	88	0	88	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,045	0	1,045	0	1,045	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	140	0	140	0	140	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	149	0	149	0	149	33.00
34.00	SPIRITUAL COUNSELING	86	0	86	0	86	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	101	0	101	0	101	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	353	0	353	0	353	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1,962	0	1,962	0	1,962	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	88	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1,045	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	140	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	149	33.00
34.00	SPIRITUAL COUNSELING	0	86	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	101	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN			38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	353	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,962	100.00

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

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION	Provider CCN: 15-0045 Hospice CCN: 15-1559	Period: From 10/01/2015 To 09/30/2016	Worksheet O-5 Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	281	281	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	12,719	1,980	14,699	3.00
4.00	ADMINISTRATIVE & GENERAL	179,404	53,582	232,986	4.00
5.00	PLANT OPERATION & MAINTENANCE	617	9,499	10,116	5.00
6.00	LAUNDRY & LINEN SERVICE	0	61	61	6.00
7.00	HOUSEKEEPING	0	3,039	3,039	7.00
8.00	DIETARY	3,628	0	3,628	8.00
9.00	NURSING ADMINISTRATION	0	9,367	9,367	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	4,564	4,564	11.00
12.00	STAFF TRANSPORTATION	9,234		9,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	77,845		77,845	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	117		117	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,962		1,962	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	285,526	82,373	367,899	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part I | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	281	281				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	14,699	0	0	14,699		3.00
4.00	ADMINISTRATIVE & GENERAL	232,986	0	0	0	232,986	4.00
5.00	PLANT OPERATION & MAINTENANCE	10,116	0	0	0	10,116	5.00
6.00	LAUNDRY & LINEN SERVICE	61	0	0	0	61	6.00
7.00	HOUSEKEEPING	3,039	0	0	0	3,039	7.00
8.00	DIETARY	3,628	0	0	0	3,628	8.00
9.00	NURSING ADMINISTRATION	9,367	0	0	0	9,367	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	4,564	0	0	0	4,564	11.00
12.00	STAFF TRANSPORTATION	9,234	0	0	0	9,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	77,845			14,432	92,277	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	117	22	0	22	161	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,962	259	0	245	2,466	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	367,899	281	0	14,699	367,899	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559

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

Worksheet O-6 Part I

Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	232,986					4.00
5.00	PLANT OPERATION & MAINTENANCE	17,470	27,586				5.00
6.00	LAUNDRY & LINEN SERVICE	105	0	166			6.00
7.00	HOUSEKEEPING	5,248	0		8,287		7.00
8.00	DIETARY	6,265	0		0	9,893	8.00
9.00	NURSING ADMINISTRATION	16,176	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		10.00
11.00	MEDICAL RECORDS	7,882	0		0		11.00
12.00	STAFF TRANSPORTATION	15,947	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	0	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	159,356					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	278	2,207	16	663	957	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	4,259	25,379	150	7,624	8,936	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	232,986	27,586	166	8,287	9,893	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part I | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	25,543					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		12,446			11.00
12.00	STAFF TRANSPORTATION	0			25,181		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	25,079	0	12,164	25,181	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	36	0	27	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	428	0	255	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	25,543	0	12,446	25,181	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part I | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		314,057	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	4,345	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	49,497	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	367,899	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS | Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part II | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	300					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	79,924			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-232,986	134,913	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	10,116	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	61	6.00
7.00	HOUSEKEEPING	0	0	0	0	3,039	7.00
8.00	DIETARY	0	0	0	0	3,628	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	9,367	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	4,564	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	9,234	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			78,477	0	92,277	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	24	0	117	0	161	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	276	0	1,330	0	2,466	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	281	0	14,699		232,986	100.00
101.00	UNIT COST MULTIPLIER	0.936667	0.000000	0.183912		1.726935	101.00

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

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part II | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	300					5.00
6.00	LAUNDRY & LINEN SERVICE	0	93				6.00
7.00	HOUSEKEEPING	0		300			7.00
8.00	DIETARY	0		0	93		8.00
9.00	NURSING ADMINISTRATION	0		0		2,149	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					2,110	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	24	9	24	9	3	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	276	84	276	84	36	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	27,586	166	8,287	9,893	25,543	100.00
101.00	UNIT COST MULTIPLIER	91.953333	1.784946	27.623333	106.376344	11.885993	101.00

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

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part II | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,105					10.00
11.00	MEDICAL RECORDS		4,105				11.00
12.00	STAFF TRANSPORTATION			100			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	4,012	4,012	100	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	9	9	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	84	84	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	12,446	25,181	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	3.031912	251.810000	0.000000	0.000000	101.00

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

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-6 Part II | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	4,105				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			93		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	4,012	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	9	0	9		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	84	0	84		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

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

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-7 | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.384536	0	0	0	1.00
1.01	CARDIAC REHAB	66.01	0.982943	0	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	0.621341	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.205837	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0.547100	0	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 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
1.01	CARDIAC REHAB	0	0	0	0	0	1.01
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 15-0045 | Hospice CCN: 15-1559 | Period: From 10/01/2015 To 09/30/2016 | Worksheet O-8 | Date/Time Prepared: 2/23/2017 4:56 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			314,057	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			4,012	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			78.28	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	2,889	87		9.00
10.00	Program cost (line 8 times line 9)	226,151	6,810		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			4,345	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			9	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			482.78	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	9	0		14.00
15.00	Program cost (line 13 times line 14)	4,345	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			49,497	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			84	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			589.25	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	52	16		19.00
20.00	Program cost (line 18 times line 19)	30,641	9,428		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			367,899	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			4,105	22.00
23.00	Average cost per diem (line 21 divided by line 22)			89.62	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0045	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 2/23/2017 4:56 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	271,045	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,070	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	17.92	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)	272,115	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