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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150061	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/21/2015 12:37 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/21/2015 Time: 12:37 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 DAVIESS COMMUNITY HOSPITAL (150061) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-16,546	145,806	-63,676	0	1.00
2.00	Subprovider - IPF	0	26,328	0		0	2.00
3.00	Subprovider - IRF	0	-6,012	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	DCHMC I	0		-12,507		0	10.00
10.01	NDMC/ODON II	0		56,620		0	10.01
10.02	QUICK CARE III	0		16,778		0	10.02
10.04	PEDIATRICS V	0		0		0	10.04
10.05	DAVIESS MARTIN VI	0		42,348		0	10.05
200.00	Total	0	3,770	249,045	-63,676	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1314 E. WALNUT STREET	PO Box: 760			1.00
2.00	City: WASHINGTON	State: IN	Zip Code: 47501	County: DAVIESS	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	DAVIESS COMMUNITY HOSPITAL	150061	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	DCH - PSYCH	15S061	99915	4	01/01/2003	N	P	O	4.00
5.00	Subprovider - IRF	DCH - REHAB	15T061	99915	5	01/01/2000	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	DAVIESS COMMUNITY HOSPITAL	15U061	99915		11/10/1999	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	WHITE RIVER COMMUNITY HEALTH SVCS	157189	99915		11/18/1987	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	HELPING HEART HOSPICE	151553	99915		07/11/1996				14.00
15.00	Hospital-Based Health Clinic - RHC	DAVIESS COMMUNITY HOSPITAL MC	158500	99915		12/17/2003	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	NORTH DAVIESS MEDICAL CENTER	153999	99915		12/17/2003	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	PETERSBURG MEDICAL CLINIC	158501	99915		03/30/2004	N	O	N	15.02
15.04	Hospital-Based Health Clinic - RHC V	GRAND AVENUE PEDIATRICS	158503	99915		01/27/2005	N	O	N	15.04
15.05	Hospital-Based Health Clinic - RHC VI	MARTIN MEDICAL CLINIC	158506	99915		10/31/2006	N	O	N	15.05
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	8		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

		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.	397	88	0	5	945	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.	50	10	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 12:29 pm

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 12:29 pm

		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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150061	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 12:29 pm

		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N	N	0	76.00

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

		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.		Y	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
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, §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.	2			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	214,953	0	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150061	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/21/2015 12:29 pm

		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 Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2014	12/31/2014	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2015 12:29 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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	03/18/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2015 12:29 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	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.					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.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00

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

		1.00	2.00	
	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.	NICHOLAS	EICHELMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000	NEICHELMAN@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/21/2015 12:29 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				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)	03/18/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2015 12:29 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	37	13,505	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)		37	13,505	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	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)		42	15,330	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	12	4,380		0	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	DCHMC	88.00				0	26.00
26.01	NDMC/ODON	88.01				0	26.01
26.02	QUICK CARE	88.02				0	26.02
26.04	PEDIATRICS	88.04				0	26.04
26.05	DAVIESS MARTIN	88.05				0	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		74				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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2015 12:29 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)	1,784	271	3,699			1.00
2.00	HMO and other (see instructions)	208	968				2.00
3.00	HMO IPF Subprovider	396	0				3.00
4.00	HMO IRF Subprovider	11	10				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)	1,784	271	3,699			7.00
8.00	INTENSIVE CARE UNIT	501	61	871			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		59	835			13.00
14.00	Total (see instructions)	2,285	391	5,405	0.00	287.55	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	5,021	399	5,874	0.00	43.39	16.00
17.00	SUBPROVIDER - IRF	2,045	50	2,539	0.00	17.00	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	1,259	115	2,067	0.00	3.32	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	3,270	0.00	4.88	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	DCHMC	3,463	1,735	11,988	0.00	9.67	26.00
26.01	NDMC/ODON	2,811	1,056	10,984	0.00	11.08	26.01
26.02	QUICK CARE	788	2,166	8,411	0.00	9.90	26.02
26.04	PEDIATRICS	0	5,976	9,919	0.00	6.67	26.04
26.05	DAVIESS MARTIN	2,522	864	7,956	0.00	8.75	26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	402.21	27.00
28.00	Observation Bed Days		315	1,431			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			108			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	76	145			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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/21/2015 12:29 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	732	330	1,561	1.00
2.00	HMO and other (see instructions)			59	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	732	330	1,561	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	341	27	422	16.00
17.00	SUBPROVIDER - IRF	0.00	0	167	6	205	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	DCHMC	0.00					26.00
26.01	NDMC/ODON	0.00					26.01
26.02	QUICK CARE	0.00					26.02
26.04	PEDIATRICS	0.00					26.04
26.05	DAVIESS MARTIN	0.00					26.05
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2015 12:29 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	22,891,206	0	22,891,206	1,033,696.00	22.15	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		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		4,950	0	4,950	28.00	176.79	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		5,848,083	74,675	5,922,758	210,244.00	28.17	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		22,282	0	22,282	390.00	57.13	11.00
12.00	Contract labor: Top level management and other management and administrative services		2,128,060	0	2,128,060	19,583.00	108.67	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,052,780	0	4,052,780			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,415,017	0	1,415,017			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,183	0	1,183			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	186,853	0	186,853	8,330.00	22.43	26.00
27.00	Administrative & General	5.00	1,729,719	-52,274	1,677,445	89,540.00	18.73	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	518,207	0	518,207	25,509.00	20.31	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	411,145	0	411,145	41,213.00	9.98	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	491,090	-366,188	124,902	9,783.00	12.77	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	290,065	290,065	22,720.00	12.77	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	724,657	0	724,657	26,523.00	27.32	38.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/21/2015 12:29 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	
39.00	Central Services and Supply	14.00	246,020	0	246,020	14,614.00	16.83	39.00
40.00	Pharmacy	15.00	663,096	0	663,096	18,349.00	36.14	40.00
41.00	Medical Records & Medical Records Library	16.00	520,255	0	520,255	28,698.00	18.13	41.00
42.00	Social Service	17.00	0	79,210	79,210	6,298.00	12.58	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/21/2015 12:29 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)		22,886,256	0	22,886,256	1,033,668.00	22.14	1.00
2.00	Excluded area salaries (see instructions)		5,848,083	74,675	5,922,758	210,244.00	28.17	2.00
3.00	Subtotal salaries (line 1 minus line 2)		17,038,173	-74,675	16,963,498	823,424.00	20.60	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,150,342	0	2,150,342	19,973.00	107.66	4.00
5.00	Subtotal wage-related costs (see inst.)		4,052,780	0	4,052,780	0.00	23.89	5.00
6.00	Total (sum of lines 3 thru 5)		23,241,295	-74,675	23,166,620	843,397.00	27.47	6.00
7.00	Total overhead cost (see instructions)		5,491,042	-49,187	5,441,855	291,577.00	18.66	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/21/2015 12:29 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	174,413	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	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	37,203	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,509,073	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	31,515	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)	48,881	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	122,810	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	0	17.00
18.00	Medicare Taxes - Employers Portion Only	1,478,061	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	24,528	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	42,496	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,468,980	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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V | Date/Time Prepared: 5/21/2015 12:29 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	0	0	3.00
4.00	Subprovider - IRF	0	0	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	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.04	Hospital-Based Health Clinic RHC 4	0	0	14.04
14.05	Hospital-Based Health Clinic RHC 5	0	0	14.05
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: 150061 | Component CCN: 157189 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4 | Date/Time Prepared: 5/21/2015 12:29 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	689	115	414	1,218	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	69.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		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	1.12	0.00	1.12	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			1.62	0.00	1.62	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.32	0.00	0.32	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.07	0.00	0.07	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.05	0.00	0.05	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			0.59	0.00	0.59	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	498	0	32	9	539	21.00
22.00	Skilled Nursing Visit Charges	58,477	0	3,036	1,056	62,569	22.00
23.00	Physical Therapy Visits	337	0	1	7	345	23.00
24.00	Physical Therapy Visit Charges	39,960	0	120	840	40,920	24.00
25.00	Occupational Therapy Visits	72	0	0	5	77	25.00
26.00	Occupational Therapy Visit Charges	8,640	0	0	600	9,240	26.00
27.00	Speech Pathology Visits	27	0	0	0	27	27.00
28.00	Speech Pathology Visit Charges	4,342	0	0	0	4,342	28.00
29.00	Medical Social Service Visits	1	0	0	0	1	29.00
30.00	Medical Social Service Visit Charges	174	0	0	0	174	30.00
31.00	Home Health Aide Visits	256	0	4	10	270	31.00
32.00	Home Health Aide Visit Charges	22,428	0	267	890	23,585	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,191	0	37	31	1,259	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)	134,021	0	3,423	3,386	140,830	35.00
36.00	Total Number of Episodes (standard/non outlier)	64		10	1	75	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	1,621	0	20	0	1,641	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061 Component CCN: 158500 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/21/2015 12:29 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1402 GRAND AVENUE	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	WASHINGTON	IN	47501	2.00

			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061
Component CCN: 158500

Period: From 01/01/2014 To 12/31/2014

Worksheet S-8
Date/Time Prepared: 5/21/2015 12:29 pm

		Rural Health Clinic (RHC) I	Cost
		County	
		4.00	
2.00	City, State, Zip Code, County	DAVIESS	2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061 Component CCN: 153999 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/21/2015 12:29 pm

			Rural Health Clinic (RHC) II	Cost	
			1.00		
	Clinic Address and Identification				
1.00	Street		202 NORTH WEST STREET		1.00
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	ODON	IN	47562	2.00
				1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
			Grant Award	Date	
			1.00	2.00	
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)		0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)		0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0		6.00
7.00	Appalachian Regional Commission		0		7.00
8.00	Look-Alikes		0		8.00
9.00	OTHER (SPECIFY)		0		9.00
9.01			0		9.01
9.02			0		9.02
9.03			0		9.03
9.04			0		9.04
9.05			0		9.05
9.06			0		9.06
9.07			0		9.07
9.08			0		9.08
9.09			0		9.09
9.10			0		9.10
			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061 | Component CCN: 153999 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) II | Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		DAVIESS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061 Component CCN: 158501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/21/2015 12:29 pm

		Rural Health Clinic (RHC) III	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1805 S. STATE RD. 57	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	WASHINGTON	IN	47501	2.00

			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10

			1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

			1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N	0	13.00

			Provider name	CCN number	
			1.00	2.00	
14.00	Provider name, CCN number				14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061
Component CCN: 158501

Period: From 01/01/2014 To 12/31/2014

Worksheet S-8
Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) III

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		DAVIESS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061 Component CCN: 158503 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/21/2015 12:29 pm

		Rural Health Clinic (RHC) V	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1402 GRAND AVE	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	WASHINGTON	IN	47501	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061
Component CCN: 158503

Period: From 01/01/2014 To 12/31/2014

Worksheet S-8
Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) V

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		DAVIESS				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061 Component CCN: 158506 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/21/2015 12:29 pm

		Rural Health Clinic (RHC) VI	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	12546 E US HWY 50	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	LOOGOOTEE	IN	47553	2.00
				1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 150061
Component CCN: 158506

Period: From 01/01/2014 To 12/31/2014

Worksheet S-8
Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) VI

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		MARTIN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 150061 Component CCN: 151553	Period: From 01/01/2014 To 12/31/2014	Worksheet S-9 Parts I & II Date/Time Prepared: 5/21/2015 12:29 pm
		Hospice I	

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	2,927	0	0	0	431	3,358	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3.00
4.00	General Inpatient Care	19	0	0	0	3	22	4.00
5.00	Total Hospice Days	2,946	0	0	0	434	3,380	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	66	0	0	0	0	66	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/21/2015 12:29 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)	0.436936	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,626,206	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	14,729,525	6.00
7.00	Medicaid cost (line 1 times line 6)	6,435,860	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)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,213,410	0	1,213,410	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	530,183	0	530,183	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)	530,183	0	530,183	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)	3,299,586	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	271,802	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,027,784	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,322,948	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,853,131	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,853,131	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/21/2015 12:29 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	NEW CAP REL COSTS-BLDG & FIXT		1,479,443	1,479,443	543,827	2,023,270	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,257,561	2,257,561	30,644	2,288,205	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	186,853	5,468,980	5,655,833	0	5,655,833	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,729,719	9,849,004	11,578,723	-361,613	11,217,110	5.00
6.00	00600	MAINTENANCE & REPAIRS	518,207	567,139	1,085,346	0	1,085,346	6.00
7.00	00700	OPERATION OF PLANT	0	779,055	779,055	0	779,055	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	170,970	170,970	0	170,970	8.00
9.00	00900	HOUSEKEEPING	411,145	118,524	529,669	0	529,669	9.00
10.00	01000	DIETARY	491,090	573,568	1,064,658	-793,876	270,782	10.00
11.00	01100	CAFETERIA	0	0	0	628,846	628,846	11.00
13.00	01300	NURSING ADMINISTRATION	724,657	45,490	770,147	0	770,147	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	246,020	182,660	428,680	0	428,680	14.00
15.00	01500	PHARMACY	663,096	301,241	964,337	0	964,337	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	520,255	132,301	652,556	0	652,556	16.00
17.00	01700	SOCIAL SERVICE	0	186	186	79,210	79,396	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,211,240	316,552	2,527,792	-494,610	2,033,182	30.00
31.00	03100	INTENSIVE CARE UNIT	644,777	37,853	682,630	-273	682,357	31.00
40.00	04000	SUBPROVIDER - IPF	2,052,344	286,539	2,338,883	168,058	2,506,941	40.00
41.00	04100	SUBPROVIDER - IRF	819,983	630,372	1,450,355	0	1,450,355	41.00
43.00	04300	NURSERY	0	19,577	19,577	243,131	262,708	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	919,775	1,271,797	2,191,572	-249,348	1,942,224	50.00
51.00	05100	RECOVERY ROOM	0	4,890	4,890	0	4,890	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	251,081	251,081	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,285	549,211	1,217,496	99,478	1,316,974	54.00
56.00	05600	RADIOISOTOPE	283,163	196,654	479,817	0	479,817	56.00
60.00	06000	LABORATORY	890,826	930,463	1,821,289	131,842	1,953,131	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	256,924	256,924	0	256,924	63.00
64.00	06400	INTRAVENOUS THERAPY	0	34,035	34,035	0	34,035	64.00
65.00	06500	RESPIRATORY THERAPY	572,013	126,779	698,792	0	698,792	65.00
66.00	06600	PHYSICAL THERAPY	661,083	55,708	716,791	20,706	737,497	66.00
67.00	06700	OCCUPATIONAL THERAPY	253,103	4,554	257,657	4,543	262,200	67.00
68.00	06800	SPEECH PATHOLOGY	61,332	44,704	106,036	3,373	109,409	68.00
69.00	06900	ELECTROCARDIOLOGY	67,358	61,437	128,795	0	128,795	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,671,574	1,671,574	-193,005	1,478,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	442,353	442,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,269,389	1,269,389	0	1,269,389	73.00
76.00	03020	CARDIAC REHAB	44,329	4,189	48,518	0	48,518	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	432,329	365,611	797,940	0	797,940	88.00
88.01	08801	NDMC/ODON	747,961	116,265	864,226	0	864,226	88.01
88.02	08802	QUICK CARE	524,934	121,664	646,598	0	646,598	88.02
88.04	08803	PEDIATRICS	450,152	123,488	573,640	0	573,640	88.04
88.05	08804	DAVIESS MARTIN	457,622	91,087	548,709	0	548,709	88.05
90.00	09000	CLINIC	228,297	54,071	282,368	-34,758	247,610	90.00
91.00	09100	EMERGENCY	1,062,485	666,595	1,729,080	0	1,729,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	371,017	152,480	523,497	-221,350	302,147	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	178,814	47,808	226,622	-28,622	198,000	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		945,054	945,054	-472,887	472,167	113.00
116.00	11600	HOSPICE	219,049	242,108	461,157	0	461,157	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,313,313	32,625,554	52,938,867	-203,250	52,735,617	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	127,770	127,770	0	127,770	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	2,577,893	714,276	3,292,169	203,250	3,495,419	194.00
200.00		TOTAL (SUM OF LINES 118-199)	22,891,206	33,467,600	56,358,806	0	56,358,806	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	2,023,270		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,288,205		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-175,052	5,480,781		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-593,606	10,623,504		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,085,346		6.00
7.00	00700	OPERATION OF PLANT	0	779,055		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	170,970		8.00
9.00	00900	HOUSEKEEPING	0	529,669		9.00
10.00	01000	DIETARY	0	270,782		10.00
11.00	01100	CAFETERIA	-274,967	353,879		11.00
13.00	01300	NURSING ADMINISTRATION	0	770,147		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-78,325	350,355		14.00
15.00	01500	PHARMACY	-2,767	961,570		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,475	627,081		16.00
17.00	01700	SOCIAL SERVICE	0	79,396		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,855	2,031,327		30.00
31.00	03100	INTENSIVE CARE UNIT	0	682,357		31.00
40.00	04000	SUBPROVIDER - IPF	-687,541	1,819,400		40.00
41.00	04100	SUBPROVIDER - IRF	-166,263	1,284,092		41.00
43.00	04300	NURSERY	0	262,708		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,340,775	601,449		50.00
51.00	05100	RECOVERY ROOM	0	4,890		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	251,081		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,316,974		54.00
56.00	05600	RADIOISOTOPE	-5,420	474,397		56.00
60.00	06000	LABORATORY	-15,000	1,938,131		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	256,924		63.00
64.00	06400	INTRAVENOUS THERAPY	0	34,035		64.00
65.00	06500	RESPIRATORY THERAPY	-62,520	636,272		65.00
66.00	06600	PHYSICAL THERAPY	-2,421	735,076		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	262,200		67.00
68.00	06800	SPEECH PATHOLOGY	0	109,409		68.00
69.00	06900	ELECTROCARDIOLOGY	-53,958	74,837		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,478,569		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	442,353		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,269,389		73.00
76.00	03020	CARDIAC REHAB	0	48,518		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0	797,940		88.00
88.01	08801	NDMC/ODON	0	864,226		88.01
88.02	08802	QUICK CARE	0	646,598		88.02
88.04	08803	PEDIATRICS	0	573,640		88.04
88.05	08804	DAVIESS MARTIN	0	548,709		88.05
90.00	09000	CLINIC	0	247,610		90.00
91.00	09100	EMERGENCY	-3,560	1,725,520		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	-130,796	171,351		93.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	198,000		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-472,167	0		113.00
116.00	11600	HOSPICE	0	461,157		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,092,468	48,643,149		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	127,770		192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	3,495,419		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-4,092,468	52,266,338		200.00

RECLASSIFICATIONS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/21/2015 12:29 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DIETARY RECLASS					
1.00	CAFETERIA	11.00	290,065	338,781		1.00
2.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	76,123	88,907		2.00
	TOTALS		366,188	427,688		
	B - INTEREST EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	446,522		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	26,365		2.00
	TOTALS		0	472,887		
	C - BILLING COSTS RECLASS					
1.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	27,027	28,742		1.00
	TOTALS		27,027	28,742		
	D - LAB/XRAY RECLASS					
1.00	LABORATORY	60.00	118,066	13,776		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	89,083	10,395		2.00
	TOTALS		207,149	24,171		
	E - SHARED THERAPY RECLASS					
1.00	PHYSICAL THERAPY	66.00	17,612	3,094		1.00
2.00	OCCUPATIONAL THERAPY	67.00	3,514	1,029		2.00
3.00	SPEECH PATHOLOGY	68.00	3,016	357		3.00
	TOTALS		24,142	4,480		
	F - OBSTETRICS RECLASS					
1.00	NURSERY	43.00	223,499	19,632		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	230,807	20,274		2.00
	TOTALS		454,306	39,906		
	G - INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	97,305		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,279		2.00
3.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	0	179,013		3.00
	TOTALS		0	280,597		
	I - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	442,353		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	442,353		
	J - SOCIAL SERVICES RECLASS					
1.00	SOCIAL SERVICE	17.00	79,210	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS		79,210	0		
	K - PHYSICIAN FEE					
1.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	34,758	0		1.00
2.00	SUBPROVIDER - IPF	40.00	171,979	0		2.00
	TOTALS		206,737	0		
500.00	Grand Total: Increases		1,364,759	1,720,824		500.00

RECLASSIFICATIONS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/21/2015 12:29 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DIETARY RECLASS						
1.00	DIETARY	10.00	366,188	427,688	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		366,188	427,688			
	B - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	472,887	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	472,887			
	C - BILLING COSTS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	27,027	28,742	0		1.00
	TOTALS		27,027	28,742			
	D - LAB/XRAY RECLASS						
1.00	OTHER NONREIMBURSABLE AND PHYSICIAN	194.00	207,149	24,171	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		207,149	24,171			
	E - SHARED THERAPY RECLASS						
1.00	HOME HEALTH AGENCY	101.00	24,142	4,480	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		24,142	4,480			
	F - OBSTETRICS RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	454,306	39,906	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		454,306	39,906			
	G - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	280,597	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	280,597			
	I - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	249,348	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	193,005	0		2.00
	TOTALS		0	442,353			
	J - SOCIAL SERVICES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	25,247	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	398	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	273	0	0		3.00
4.00	SUBPROVIDER - IPF	40.00	3,921	0	0		4.00
5.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	49,371	0	0		5.00
	TOTALS		79,210	0			
	K - PHYSICIAN FEE						
1.00	CLINIC	90.00	34,758	0	0		1.00
2.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	171,979	0	0		2.00
	TOTALS		206,737	0			
500.00	Grand Total: Decreases		1,364,759	1,720,824			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,280,955	0	0	0	0	1.00
2.00	Land Improvements	687,865	0	0	0	0	2.00
3.00	Buildings and Fixtures	38,572,140	130,272	0	130,272	0	3.00
4.00	Building Improvements	39,119	0	0	0	0	4.00
5.00	Fixed Equipment	3,823,019	379,220	0	379,220	0	5.00
6.00	Movable Equipment	26,274,142	658,435	0	658,435	109,026	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	70,677,240	1,167,927	0	1,167,927	109,026	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	70,677,240	1,167,927	0	1,167,927	109,026	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,280,955	0	1.00
2.00	Land Improvements	687,865	0	2.00
3.00	Buildings and Fixtures	38,702,412	0	3.00
4.00	Building Improvements	39,119	0	4.00
5.00	Fixed Equipment	4,202,239	0	5.00
6.00	Movable Equipment	26,823,551	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	71,736,141	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	71,736,141	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/21/2015 12:29 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	NEW CAP REL COSTS-BLDG & FIXT	1,252,720	6,000	220,723	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,836,005	338,826	0	0	82,730	2.00
3.00	Total (sum of lines 1-2)	3,088,725	344,826	220,723	0	82,730	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,479,443	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,257,561	2.00
3.00	Total (sum of lines 1-2)	0	3,737,004	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/21/2015 12:29 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	44,912,590	0	44,912,590	0.626080	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	26,823,551	0	26,823,551	0.373920	0	2.00
3.00	Total (sum of lines 1-2)	71,736,141	0	71,736,141	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,252,720	6,000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,836,005	338,826	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,088,725	344,826	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	667,245	97,305	0	0	2,023,270	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	26,365	4,279	82,730	0	2,288,205	2.00
3.00	Total (sum of lines 1-2)	693,610	101,584	82,730	0	4,311,475	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/21/2015 12:29 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-78,325	CENTRAL SERVICES & SUPPLY	14.00	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)	A	-8,370	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,462,273			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		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-274,967	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	-2,767	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-25,475	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)	A	-433	ADMINISTRATIVE & GENERAL	5.00	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/21/2015 12:29 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADVERTISING EXPENSES	A	-297,746	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN RECRUITMENT EXPENSES	A	-257,896	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PUBLIC RELATIONS	A	-16,050	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	NON-ALLOWABLE COSTS	A	-8,892	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	NON-ALLOWABLE COSTS	A	-2,421	PHYSICAL THERAPY	66.00	0	35.02
35.03	DONATIONS	A	-7,100	ADMINISTRATIVE & GENERAL	5.00	0	35.03
35.04	PHYSICIAN BENEFITS	A	-175,052	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.04
36.00	CPR CLASS INCOME	B	-3,560	EMERGENCY	91.00	0	36.00
36.01	MISC. INCOME	B	-17,803	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	INTEREST EXPENSE OFFSET	A	-472,167	INTEREST EXPENSE	113.00	0	36.02
38.00	NON-ALLOWABLE COSTS	A	-1,855	ADULTS & PEDIATRICS	30.00	0	38.00
39.00	LOBBYING EXPENSE	A	-741	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	DEBT ISSUANCE COST AMORTIZATION	A	21,425	ADMINISTRATIVE & GENERAL	5.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,092,468				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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/21/2015 12:29 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	40.00	SUBPROVIDER - IPF	687,541	687,541	0	0	0	1.00
2.00	41.00	SUBPROVIDER - IRF	166,263	166,263	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,340,775	1,340,775	0	0	0	3.00
4.00	56.00	RADIOISOTOPE	5,420	5,420	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	62,520	62,520	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	53,958	53,958	0	0	0	6.00
7.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	130,796	130,796	0	0	0	7.00
8.00	60.00	LABORATORY	15,000	15,000	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,462,273	2,462,273	0		0	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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	56.00	RADIOISOTOPE	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	40.00	SUBPROVIDER - IPF	0	0	0	687,541		1.00
2.00	41.00	SUBPROVIDER - IRF	0	0	0	166,263		2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,340,775		3.00
4.00	56.00	RADIOISOTOPE	0	0	0	5,420		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	62,520		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,958		6.00
7.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	130,796		7.00
8.00	60.00	LABORATORY	0	0	0	15,000		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,462,273		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,023,270	2,023,270				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,288,205		2,288,205			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,480,781	5,176	0	5,485,957		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,623,504	116,049	1,880,394	405,314	13,025,261	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,085,346	63,611	0	125,212	1,274,169	6.00
7.00	00700	OPERATION OF PLANT	779,055	409,044	0	0	1,188,099	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	170,970	4,403	0	0	175,373	8.00
9.00	00900	HOUSEKEEPING	529,669	14,576	973	99,343	644,561	9.00
10.00	01000	DIETARY	270,782	38,221	0	30,180	339,183	10.00
11.00	01100	CAFETERIA	353,879	14,001	0	70,087	437,967	11.00
13.00	01300	NURSING ADMINISTRATION	770,147	28,124	8,153	175,096	981,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	350,355	42,285	0	59,445	452,085	14.00
15.00	01500	PHARMACY	961,570	17,112	83,514	160,221	1,222,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	627,081	93,318	38,782	125,707	884,888	16.00
17.00	01700	SOCIAL SERVICE	79,396	0	142	19,139	98,677	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,031,327	89,312	8,470	424,425	2,553,534	30.00
31.00	03100	INTENSIVE CARE UNIT	682,357	22,542	0	155,729	860,628	31.00
40.00	04000	SUBPROVIDER - IPF	1,819,400	92,790	24,709	536,507	2,473,406	40.00
41.00	04100	SUBPROVIDER - IRF	1,284,092	81,779	0	198,129	1,564,000	41.00
43.00	04300	NURSERY	262,708	8,975	449	54,003	326,135	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	601,449	118,133	20,287	222,242	962,111	50.00
51.00	05100	RECOVERY ROOM	4,890	16,424	2,680	0	23,994	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	251,081	92,922	7,526	55,769	407,298	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,316,974	114,701	11,730	183,000	1,626,405	54.00
56.00	05600	RADIOISOTOPE	474,397	10,729	22,297	68,420	575,843	56.00
60.00	06000	LABORATORY	1,938,131	32,112	258	243,775	2,214,276	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	256,924	1,876	1,821	0	260,621	63.00
64.00	06400	INTRAVENOUS THERAPY	34,035	0	13,650	0	47,685	64.00
65.00	06500	RESPIRATORY THERAPY	636,272	24,673	0	138,213	799,158	65.00
66.00	06600	PHYSICAL THERAPY	735,076	31,603	0	163,990	930,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,200	6,732	0	62,005	330,937	67.00
68.00	06800	SPEECH PATHOLOGY	109,409	4,771	1,367	15,548	131,095	68.00
69.00	06900	ELECTROCARDIOLOGY	74,837	5,845	5,384	16,275	102,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,478,569	0	460	0	1,479,029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	442,353	0	0	0	442,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,269,389	3,026	0	0	1,272,415	73.00
76.00	03020	CARDIAC REHAB	48,518	21,684	0	10,711	80,913	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	797,940	45,867	0	104,462	948,269	88.00
88.01	08801	NDMC/ODON	864,226	32,847	9,245	180,727	1,087,045	88.01
88.02	08802	QUICK CARE	646,598	50,487	0	126,838	823,923	88.02
88.04	08803	PEDIATRICS	573,640	18,309	0	108,768	700,717	88.04
88.05	08804	DAVIESS MARTIN	548,709	24,051	20,472	110,573	703,805	88.05
90.00	09000	CLINIC	247,610	35,440	5,443	46,764	335,257	90.00
91.00	09100	EMERGENCY	1,725,520	79,667	0	256,724	2,061,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	171,351	55,003	0	36,163	262,517	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	198,000	12,869	0	37,373	248,242	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	461,157	5,515	0	52,928	519,600	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,643,149	1,986,604	2,168,206	4,879,805	47,880,332	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127,770	0	16,388	0	144,158	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	3,495,419	36,666	103,611	606,152	4,241,848	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	52,266,338	2,023,270	2,288,205	5,485,957	52,266,338	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,025,261					5.00
6.00	00600	MAINTENANCE & REPAIRS	422,934	1,697,103				6.00
7.00	00700	OPERATION OF PLANT	394,365	377,601	1,960,065			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,211	4,064	6,037	243,685		8.00
9.00	00900	HOUSEKEEPING	213,948	13,455	19,987	0	891,951	9.00
10.00	01000	DIETARY	112,585	35,283	52,411	975	24,171	10.00
11.00	01100	CAFETERIA	145,374	12,924	19,198	0	8,854	11.00
13.00	01300	NURSING ADMINISTRATION	325,795	25,962	38,565	0	17,786	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	150,060	39,034	57,983	0	26,741	14.00
15.00	01500	PHARMACY	405,756	15,796	23,465	0	10,822	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	293,720	86,145	127,964	0	59,015	16.00
17.00	01700	SOCIAL SERVICE	32,754	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	847,592	82,446	122,469	109,660	56,481	30.00
31.00	03100	INTENSIVE CARE UNIT	285,667	20,809	30,911	24,368	14,256	31.00
40.00	04000	SUBPROVIDER - IPF	820,995	85,657	127,240	24,368	58,681	40.00
41.00	04100	SUBPROVIDER - IRF	519,137	75,492	112,140	24,368	51,717	41.00
43.00	04300	NURSERY	108,254	8,285	12,308	0	5,676	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	319,353	109,051	161,991	34,116	74,706	50.00
51.00	05100	RECOVERY ROOM	7,964	15,161	22,521	0	10,386	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,194	85,779	127,421	0	58,765	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	539,851	105,883	157,285	1,462	72,538	54.00
56.00	05600	RADIOISOTOPE	191,139	9,904	14,712	0	6,785	56.00
60.00	06000	LABORATORY	734,982	29,643	44,034	0	20,308	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	86,508	1,732	2,573	0	1,187	63.00
64.00	06400	INTRAVENOUS THERAPY	15,828	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	265,264	22,776	33,833	0	15,603	65.00
66.00	06600	PHYSICAL THERAPY	308,916	29,173	43,335	0	19,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	109,848	6,214	9,231	0	4,257	67.00
68.00	06800	SPEECH PATHOLOGY	43,514	4,404	6,542	0	3,017	68.00
69.00	06900	ELECTROCARDIOLOGY	33,970	5,396	8,016	0	3,697	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	490,933	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	146,830	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	422,351	2,794	4,150	0	1,914	73.00
76.00	03020	CARDIAC REHAB	26,857	20,017	29,735	0	13,713	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	314,758	42,341	62,896	0	29,007	88.00
88.01	08801	NDMC/ODON	360,822	30,322	45,042	0	20,773	88.01
88.02	08802	QUICK CARE	273,484	46,606	69,231	0	31,928	88.02
88.04	08803	PEDIATRICS	232,588	16,902	25,107	0	11,579	88.04
88.05	08804	DAVIESS MARTIN	233,613	22,202	32,980	0	15,210	88.05
90.00	09000	CLINIC	111,282	32,715	48,597	0	22,412	90.00
91.00	09100	EMERGENCY	684,408	73,542	109,244	24,368	50,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	87,137	50,775	75,423	0	34,784	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	82,399	11,880	17,647	0	8,139	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	172,470	5,091	7,563	0	3,488	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,569,410	1,663,256	1,909,787	243,685	868,764	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	47,850	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	1,408,001	33,847	50,278	0	23,187	194.00
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)	13,025,261	1,697,103	1,960,065	243,685	891,951	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	564,608					10.00
11.00	01100	CAFETERIA	0	624,317				11.00
13.00	01300	NURSING ADMINISTRATION	0	20,065	1,409,693			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,056	0	736,959		14.00
15.00	01500	PHARMACY	0	13,882	0	444	1,692,582	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,711	0	11	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,743	0	51	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	168,614	75,517	286,469	17,516	0	30.00
31.00	03100	INTENSIVE CARE UNIT	51,597	22,975	87,152	4,189	0	31.00
40.00	04000	SUBPROVIDER - IPF	244,968	68,279	259,004	7,260	0	40.00
41.00	04100	SUBPROVIDER - IRF	99,429	26,752	101,477	3,459	0	41.00
43.00	04300	NURSERY	0	8,466	32,113	4,888	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,649	120,053	19,005	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	276	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,742	33,160	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,702	120,257	12,922	0	54.00
56.00	05600	RADIOISOTOPE	0	8,016	30,408	1,241	0	56.00
60.00	06000	LABORATORY	0	41,819	158,632	134,010	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	58,932	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	18,253	0	7,873	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,529	0	252	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,021	0	29	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,445	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,300	0	684	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	423,881	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,692,582	73.00
76.00	03020	CARDIAC REHAB	0	1,345	5,102	126	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	15,213	0	556	0	88.00
88.01	08801	NDMC/ODON	0	17,437	0	2,070	0	88.01
88.02	08802	QUICK CARE	0	15,575	0	1,493	0	88.02
88.04	08803	PEDIATRICS	0	10,492	0	1,092	0	88.04
88.05	08804	DAVIESS MARTIN	0	13,772	0	872	0	88.05
90.00	09000	CLINIC	0	2,561	0	8,041	0	90.00
91.00	09100	EMERGENCY	0	33,449	126,883	7,748	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	5,524	0	54	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	5,231	19,841	95	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	7,683	29,142	14,529	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	564,608	573,204	1,409,693	733,599	1,692,582	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	51,113	0	3,360	0	194.00
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)	564,608	624,317	1,409,693	736,959	1,692,582	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,473,454					16.00
17.00	01700	SOCIAL SERVICE	0	136,225				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,626	225	4,368,149	0	4,368,149	30.00
31.00	03100	INTENSIVE CARE UNIT	35,991	150	1,438,693	0	1,438,693	31.00
40.00	04000	SUBPROVIDER - IPF	109,393	2,901	4,282,152	0	4,282,152	40.00
41.00	04100	SUBPROVIDER - IRF	39,658	0	2,617,629	0	2,617,629	41.00
43.00	04300	NURSERY	8,676	0	514,801	0	514,801	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,837	0	1,952,872	0	1,952,872	50.00
51.00	05100	RECOVERY ROOM	9,785	0	90,087	0	90,087	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,960	0	865,319	0	865,319	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	202,102	0	2,870,407	0	2,870,407	54.00
56.00	05600	RADIOISOTOPE	60,511	0	898,559	0	898,559	56.00
60.00	06000	LABORATORY	267,837	0	3,645,541	0	3,645,541	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,454	0	424,007	0	424,007	63.00
64.00	06400	INTRAVENOUS THERAPY	10,301	543	74,357	0	74,357	64.00
65.00	06500	RESPIRATORY THERAPY	45,130	0	1,207,890	0	1,207,890	65.00
66.00	06600	PHYSICAL THERAPY	38,139	0	1,390,999	0	1,390,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,983	0	485,520	0	485,520	67.00
68.00	06800	SPEECH PATHOLOGY	3,941	0	193,958	0	193,958	68.00
69.00	06900	ELECTROCARDIOLOGY	16,054	0	172,458	0	172,458	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,909	0	2,450,752	0	2,450,752	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,734	0	598,917	0	598,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	97,081	0	3,493,287	0	3,493,287	73.00
76.00	03020	CARDIAC REHAB	1,117	0	178,925	0	178,925	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	20,145	0	1,433,185	0	1,433,185	88.00
88.01	08801	NDMC/ODON	18,125	0	1,581,636	0	1,581,636	88.01
88.02	08802	QUICK CARE	20,018	0	1,282,258	0	1,282,258	88.02
88.04	08803	PEDIATRICS	16,950	0	1,015,427	0	1,015,427	88.04
88.05	08804	DAVIESS MARTIN	14,570	0	1,037,024	0	1,037,024	88.05
90.00	09000	CLINIC	24,913	0	585,778	0	585,778	90.00
91.00	09100	EMERGENCY	104,006	0	3,275,941	0	3,275,941	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	14,972	40,611	571,797	0	571,797	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,221	36,718	432,413	0	432,413	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	11,558	55,077	826,201	0	826,201	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,467,697	136,225	46,256,939	0	46,256,939	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192,008	0	192,008	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	5,757	0	5,817,391	0	5,817,391	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,473,454	136,225	52,266,338	0	52,266,338	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,176	0	5,176	5,176	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	116,049	1,880,394	1,996,443	382	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	63,611	0	63,611	118	6.00
7.00	00700	OPERATION OF PLANT	0	409,044	0	409,044	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,403	0	4,403	0	8.00
9.00	00900	HOUSEKEEPING	0	14,576	973	15,549	94	9.00
10.00	01000	DIETARY	0	38,221	0	38,221	28	10.00
11.00	01100	CAFETERIA	0	14,001	0	14,001	66	11.00
13.00	01300	NURSING ADMINISTRATION	0	28,124	8,153	36,277	165	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	42,285	0	42,285	56	14.00
15.00	01500	PHARMACY	0	17,112	83,514	100,626	151	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	93,318	38,782	132,100	119	16.00
17.00	01700	SOCIAL SERVICE	0	0	142	142	18	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	89,312	8,470	97,782	400	30.00
31.00	03100	INTENSIVE CARE UNIT	0	22,542	0	22,542	147	31.00
40.00	04000	SUBPROVIDER - IPF	0	92,790	24,709	117,499	506	40.00
41.00	04100	SUBPROVIDER - IRF	0	81,779	0	81,779	187	41.00
43.00	04300	NURSERY	0	8,975	449	9,424	51	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	118,133	20,287	138,420	210	50.00
51.00	05100	RECOVERY ROOM	0	16,424	2,680	19,104	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	92,922	7,526	100,448	53	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114,701	11,730	126,431	173	54.00
56.00	05600	RADIOISOTOPE	0	10,729	22,297	33,026	65	56.00
60.00	06000	LABORATORY	0	32,112	258	32,370	230	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,876	1,821	3,697	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	13,650	13,650	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	24,673	0	24,673	130	65.00
66.00	06600	PHYSICAL THERAPY	0	31,603	0	31,603	155	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,732	0	6,732	59	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,771	1,367	6,138	15	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,845	5,384	11,229	15	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	460	460	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,026	0	3,026	0	73.00
76.00	03020	CARDIAC REHAB	0	21,684	0	21,684	10	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	45,867	0	45,867	99	88.00
88.01	08801	NDMC/ODON	0	32,847	9,245	42,092	171	88.01
88.02	08802	QUICK CARE	0	50,487	0	50,487	120	88.02
88.04	08803	PEDIATRICS	0	18,309	0	18,309	103	88.04
88.05	08804	DAVIESS MARTIN	0	24,051	20,472	44,523	104	88.05
90.00	09000	CLINIC	0	35,440	5,443	40,883	44	90.00
91.00	09100	EMERGENCY	0	79,667	0	79,667	242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	55,003	0	55,003	34	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	12,869	0	12,869	35	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	5,515	0	5,515	50	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,986,604	2,168,206	4,154,810	4,605	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	16,388	16,388	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	36,666	103,611	140,277	571	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,023,270	2,288,205	4,311,475	5,176	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,996,825					5.00
6.00	00600	MAINTENANCE & REPAIRS	64,837	128,566				6.00
7.00	00700	OPERATION OF PLANT	60,458	28,606	498,108			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,924	308	1,534	15,169		8.00
9.00	00900	HOUSEKEEPING	32,799	1,019	5,079	0	54,540	9.00
10.00	01000	DIETARY	17,260	2,673	13,319	61	1,478	10.00
11.00	01100	CAFETERIA	22,286	979	4,879	0	541	11.00
13.00	01300	NURSING ADMINISTRATION	49,946	1,967	9,800	0	1,088	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,005	2,957	14,735	0	1,635	14.00
15.00	01500	PHARMACY	62,204	1,197	5,963	0	662	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45,028	6,526	32,519	0	3,609	16.00
17.00	01700	SOCIAL SERVICE	5,021	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	129,939	6,246	31,123	6,825	3,454	30.00
31.00	03100	INTENSIVE CARE UNIT	43,794	1,576	7,855	1,517	872	31.00
40.00	04000	SUBPROVIDER - IPF	125,862	6,489	32,335	1,517	3,588	40.00
41.00	04100	SUBPROVIDER - IRF	79,586	5,719	28,498	1,517	3,162	41.00
43.00	04300	NURSERY	16,596	628	3,128	0	347	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,958	8,261	41,169	2,124	4,568	50.00
51.00	05100	RECOVERY ROOM	1,221	1,149	5,723	0	635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,726	6,498	32,381	0	3,593	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,761	8,021	39,971	91	4,435	54.00
56.00	05600	RADIOISOTOPE	29,302	750	3,739	0	415	56.00
60.00	06000	LABORATORY	112,676	2,246	11,190	0	1,242	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	13,262	131	654	0	73	63.00
64.00	06400	INTRAVENOUS THERAPY	2,426	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	40,666	1,725	8,598	0	954	65.00
66.00	06600	PHYSICAL THERAPY	47,358	2,210	11,013	0	1,222	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,840	471	2,346	0	260	67.00
68.00	06800	SPEECH PATHOLOGY	6,671	334	1,662	0	184	68.00
69.00	06900	ELECTROCARDIOLOGY	5,208	409	2,037	0	226	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75,262	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	22,510	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,748	212	1,055	0	117	73.00
76.00	03020	CARDIAC REHAB	4,117	1,516	7,556	0	839	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	48,254	3,208	15,984	0	1,774	88.00
88.01	08801	NDMC/ODON	55,315	2,297	11,446	0	1,270	88.01
88.02	08802	QUICK CARE	41,926	3,531	17,593	0	1,952	88.02
88.04	08803	PEDIATRICS	35,657	1,280	6,380	0	708	88.04
88.05	08804	DAVIESS MARTIN	35,814	1,682	8,381	0	930	88.05
90.00	09000	CLINIC	17,060	2,478	12,350	0	1,370	90.00
91.00	09100	EMERGENCY	104,922	5,571	27,762	1,517	3,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	13,358	3,846	19,167	0	2,127	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	12,632	900	4,485	0	498	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	26,440	386	1,922	0	213	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,773,635	126,002	485,331	15,169	53,122	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,336	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	215,854	2,564	12,777	0	1,418	194.00
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)	1,996,825	128,566	498,108	15,169	54,540	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	73,040					10.00
11.00	01100	CAFETERIA	0	42,752				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,374	100,617			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	757	0	85,430		14.00
15.00	01500	PHARMACY	0	951	0	51	171,805	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,487	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	325	0	6	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,813	5,170	20,449	2,031	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,675	1,573	6,220	486	0	31.00
40.00	04000	SUBPROVIDER - IPF	31,689	4,676	18,486	842	0	40.00
41.00	04100	SUBPROVIDER - IRF	12,863	1,832	7,243	401	0	41.00
43.00	04300	NURSERY	0	580	2,292	567	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,167	8,569	2,203	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	32	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	599	2,367	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,171	8,583	1,498	0	54.00
56.00	05600	RADIOISOTOPE	0	549	2,170	144	0	56.00
60.00	06000	LABORATORY	0	2,864	11,322	15,535	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	6,832	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,250	0	913	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,406	0	29	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	481	0	3	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	99	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	157	0	79	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,136	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	171,805	73.00
76.00	03020	CARDIAC REHAB	0	92	364	15	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	1,042	0	64	0	88.00
88.01	08801	NDMC/ODON	0	1,194	0	240	0	88.01
88.02	08802	QUICK CARE	0	1,067	0	173	0	88.02
88.04	08803	PEDIATRICS	0	718	0	127	0	88.04
88.05	08804	DAVIESS MARTIN	0	943	0	101	0	88.05
90.00	09000	CLINIC	0	175	0	932	0	90.00
91.00	09100	EMERGENCY	0	2,291	9,056	898	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	378	0	6	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	358	1,416	11	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	526	2,080	1,684	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,040	39,252	100,617	85,040	171,805	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0	3,500	0	390	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	73,040	42,752	100,617	85,430	171,805	202.00

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		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	221,389					16.00
17.00	01700	SOCIAL SERVICE	0	5,512				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,154	9	332,395	0	332,395	30.00
31.00	03100	INTENSIVE CARE UNIT	5,406	6	98,669	0	98,669	31.00
40.00	04000	SUBPROVIDER - IPF	16,433	117	360,039	0	360,039	40.00
41.00	04100	SUBPROVIDER - IRF	5,957	0	228,744	0	228,744	41.00
43.00	04300	NURSERY	1,303	0	34,916	0	34,916	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,152	0	274,801	0	274,801	50.00
51.00	05100	RECOVERY ROOM	1,470	0	29,334	0	29,334	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,346	0	168,011	0	168,011	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,360	0	304,495	0	304,495	54.00
56.00	05600	RADIOISOTOPE	9,090	0	79,250	0	79,250	56.00
60.00	06000	LABORATORY	40,284	0	229,959	0	229,959	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,871	0	26,520	0	26,520	63.00
64.00	06400	INTRAVENOUS THERAPY	1,547	22	17,645	0	17,645	64.00
65.00	06500	RESPIRATORY THERAPY	6,779	0	85,688	0	85,688	65.00
66.00	06600	PHYSICAL THERAPY	5,729	0	100,725	0	100,725	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,701	0	29,893	0	29,893	67.00
68.00	06800	SPEECH PATHOLOGY	592	0	15,695	0	15,695	68.00
69.00	06900	ELECTROCARDIOLOGY	2,412	0	21,772	0	21,772	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,549	0	133,407	0	133,407	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,462	0	23,972	0	23,972	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,583	0	255,546	0	255,546	73.00
76.00	03020	CARDIAC REHAB	168	0	36,361	0	36,361	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	3,026	0	119,318	0	119,318	88.00
88.01	08801	NDMC/ODON	2,723	0	116,748	0	116,748	88.01
88.02	08802	QUICK CARE	3,007	0	119,856	0	119,856	88.02
88.04	08803	PEDIATRICS	2,546	0	65,828	0	65,828	88.04
88.05	08804	DAVIESS MARTIN	2,189	0	94,667	0	94,667	88.05
90.00	09000	CLINIC	3,742	0	79,034	0	79,034	90.00
91.00	09100	EMERGENCY	15,624	0	250,631	0	250,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	2,249	1,643	97,811	0	97,811	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	334	1,486	35,024	0	35,024	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,736	2,229	42,781	0	42,781	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	220,524	5,512	3,909,535	0	3,909,535	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	23,724	0	23,724	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	865	0	378,216	0	378,216	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	221,389	5,512	4,311,475	0	4,311,475	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	214,602					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,109,776				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	549	0	22,704,353			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,309	911,989	1,677,445	-13,025,261	39,241,077	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,747	0	518,207	0	1,274,169	6.00
7.00	00700	OPERATION OF PLANT	43,386	0	0	0	1,188,099	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467	0	0	0	175,373	8.00
9.00	00900	HOUSEKEEPING	1,546	472	411,145	0	644,561	9.00
10.00	01000	DIETARY	4,054	0	124,902	0	339,183	10.00
11.00	01100	CAFETERIA	1,485	0	290,065	0	437,967	11.00
13.00	01300	NURSING ADMINISTRATION	2,983	3,954	724,657	0	981,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,485	0	246,020	0	452,085	14.00
15.00	01500	PHARMACY	1,815	40,504	663,096	0	1,222,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,898	18,809	520,255	0	884,888	16.00
17.00	01700	SOCIAL SERVICE	0	69	79,210	0	98,677	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,473	4,108	1,756,536	0	2,553,534	30.00
31.00	03100	INTENSIVE CARE UNIT	2,391	0	644,504	0	860,628	31.00
40.00	04000	SUBPROVIDER - IPF	9,842	11,984	2,220,402	0	2,473,406	40.00
41.00	04100	SUBPROVIDER - IRF	8,674	0	819,983	0	1,564,000	41.00
43.00	04300	NURSERY	952	218	223,499	0	326,135	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,530	9,839	919,775	0	962,111	50.00
51.00	05100	RECOVERY ROOM	1,742	1,300	0	0	23,994	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,856	3,650	230,807	0	407,298	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,166	5,689	757,368	0	1,626,405	54.00
56.00	05600	RADIOISOTOPE	1,138	10,814	283,163	0	575,843	56.00
60.00	06000	LABORATORY	3,406	125	1,008,892	0	2,214,276	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199	883	0	0	260,621	63.00
64.00	06400	INTRAVENOUS THERAPY	0	6,620	0	0	47,685	64.00
65.00	06500	RESPIRATORY THERAPY	2,617	0	572,013	0	799,158	65.00
66.00	06600	PHYSICAL THERAPY	3,352	0	678,695	0	930,669	66.00
67.00	06700	OCCUPATIONAL THERAPY	714	0	256,617	0	330,937	67.00
68.00	06800	SPEECH PATHOLOGY	506	663	64,348	0	131,095	68.00
69.00	06900	ELECTROCARDIOLOGY	620	2,611	67,358	0	102,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	223	0	0	1,479,029	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	442,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321	0	0	0	1,272,415	73.00
76.00	03020	CARDIAC REHAB	2,300	0	44,329	0	80,913	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	4,865	0	432,329	0	948,269	88.00
88.01	08801	NDMC/ODON	3,484	4,484	747,961	0	1,087,045	88.01
88.02	08802	QUICK CARE	5,355	0	524,934	0	823,923	88.02
88.04	08803	PEDIATRICS	1,942	0	450,152	0	700,717	88.04
88.05	08804	DAVIESS MARTIN	2,551	9,929	457,622	0	703,805	88.05
90.00	09000	CLINIC	3,759	2,640	193,539	0	335,257	90.00
91.00	09100	EMERGENCY	8,450	0	1,062,485	0	2,061,911	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	5,834	0	149,667	0	262,517	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,365	0	154,672	0	248,242	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	585	0	219,049	0	519,600	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	210,713	1,051,577	20,195,701	-13,025,261	34,855,071	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,948	0	0	144,158	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	3,889	50,251	2,508,652	0	4,241,848	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,023,270	2,288,205	5,485,957		13,025,261	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.428011	2.061862	0.241626		0.331929	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,176		1,996,825	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000228		0.050886	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	194,997					6.00
7.00	00700	OPERATION OF PLANT	43,386	151,611				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467	467	438,000			8.00
9.00	00900	HOUSEKEEPING	1,546	1,546	0	149,598		9.00
10.00	01000	DIETARY	4,054	4,054	1,752	4,054	42,600	10.00
11.00	01100	CAFETERIA	1,485	1,485	0	1,485	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,983	2,983	0	2,983	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,485	4,485	0	4,485	0	14.00
15.00	01500	PHARMACY	1,815	1,815	0	1,815	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,898	9,898	0	9,898	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	9,473	9,473	197,100	9,473	12,722	30.00
31.00	03100	INTENSIVE CARE UNIT	2,391	2,391	43,800	2,391	3,893	31.00
40.00	04000	SUBPROVIDER - IPF	9,842	9,842	43,800	9,842	18,483	40.00
41.00	04100	SUBPROVIDER - IRF	8,674	8,674	43,800	8,674	7,502	41.00
43.00	04300	NURSERY	952	952	0	952	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,530	12,530	61,320	12,530	0	50.00
51.00	05100	RECOVERY ROOM	1,742	1,742	0	1,742	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,856	9,856	0	9,856	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,166	12,166	2,628	12,166	0	54.00
56.00	05600	RADIOISOTOPE	1,138	1,138	0	1,138	0	56.00
60.00	06000	LABORATORY	3,406	3,406	0	3,406	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	199	199	0	199	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,617	2,617	0	2,617	0	65.00
66.00	06600	PHYSICAL THERAPY	3,352	3,352	0	3,352	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	714	714	0	714	0	67.00
68.00	06800	SPEECH PATHOLOGY	506	506	0	506	0	68.00
69.00	06900	ELECTROCARDIOLOGY	620	620	0	620	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	321	321	0	321	0	73.00
76.00	03020	CARDIAC REHAB	2,300	2,300	0	2,300	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	4,865	4,865	0	4,865	0	88.00
88.01	08801	NDMC/ODON	3,484	3,484	0	3,484	0	88.01
88.02	08802	QUICK CARE	5,355	5,355	0	5,355	0	88.02
88.04	08803	PEDIATRICS	1,942	1,942	0	1,942	0	88.04
88.05	08804	DAVIESS MARTIN	2,551	2,551	0	2,551	0	88.05
90.00	09000	CLINIC	3,759	3,759	0	3,759	0	90.00
91.00	09100	EMERGENCY	8,450	8,450	43,800	8,450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	5,834	5,834	0	5,834	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,365	1,365	0	1,365	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	585	585	0	585	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	191,108	147,722	438,000	145,709	42,600	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	3,889	3,889	0	3,889	0	194.00
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)	1,697,103	1,960,065	243,685	891,951	564,608	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.703226	12.928251	0.556358	5.962319	13.253709	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	128,566	498,108	15,169	54,540	73,040	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.659323	3.285434	0.034632	0.364577	1.714554	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	825,236					11.00
13.00	01300	NURSING ADMINISTRATION	26,523	491,224				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,614	0	2,906,190			14.00
15.00	01500	PHARMACY	18,349	0	1,751	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,698	0	42	0	107,867,651	16.00
17.00	01700	SOCIAL SERVICE	6,269	0	201	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,823	99,823	69,076	0	3,486,552	30.00
31.00	03100	INTENSIVE CARE UNIT	30,369	30,369	16,520	0	2,634,741	31.00
40.00	04000	SUBPROVIDER - IPF	90,253	90,253	28,630	0	8,008,259	40.00
41.00	04100	SUBPROVIDER - IRF	35,361	35,361	13,639	0	2,903,211	41.00
43.00	04300	NURSERY	11,190	11,190	19,274	0	635,162	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	41,834	41,834	74,944	0	8,846,035	50.00
51.00	05100	RECOVERY ROOM	0	0	1,089	0	716,300	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,555	11,555	0	0	655,931	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,905	41,905	50,956	0	14,795,181	54.00
56.00	05600	RADIOISOTOPE	10,596	10,596	4,892	0	4,429,810	56.00
60.00	06000	LABORATORY	55,277	55,277	528,467	0	19,608,772	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	232,397	0	911,702	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	754,070	64.00
65.00	06500	RESPIRATORY THERAPY	24,127	0	31,049	0	3,303,803	65.00
66.00	06600	PHYSICAL THERAPY	27,136	0	994	0	2,792,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,281	0	113	0	1,316,474	67.00
68.00	06800	SPEECH PATHOLOGY	1,910	0	0	0	288,470	68.00
69.00	06900	ELECTROCARDIOLOGY	3,040	0	2,697	0	1,175,251	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,671,574	0	4,166,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	712,595	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	7,106,961	73.00
76.00	03020	CARDIAC REHAB	1,778	1,778	497	0	81,742	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	20,109	0	2,194	0	1,474,714	88.00
88.01	08801	NDMC/ODON	23,048	0	8,163	0	1,326,840	88.01
88.02	08802	QUICK CARE	20,587	0	5,888	0	1,465,431	88.02
88.04	08803	PEDIATRICS	13,868	0	4,306	0	1,240,873	88.04
88.05	08804	DAVIESS MARTIN	18,204	0	3,437	0	1,066,618	88.05
90.00	09000	CLINIC	3,385	0	31,711	0	1,823,824	90.00
91.00	09100	EMERGENCY	44,214	44,214	30,554	0	7,613,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	7,302	0	214	0	1,096,054	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	6,914	6,914	373	0	162,582	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	10,155	10,155	57,296	0	846,110	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	757,674	491,224	2,892,938	100	107,446,174	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	67,562	0	13,252	0	421,477	194.00
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)	624,317	1,409,693	736,959	1,692,582	1,473,454	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.756531	2.869756	0.253583	16,925.820000	0.013660	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,752	100,617	85,430	171,805	221,389	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.051806	0.204829	0.029396	1,718.050000	0.002052	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/21/2015 12:29 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
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	7,279		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	12		30.00
31.00	03100	INTENSIVE CARE UNIT	8		31.00
40.00	04000	SUBPROVIDER - IPF	155		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
56.00	05600	RADIOISOTOPE	0		56.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	29		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	03020	CARDIAC REHAB	0		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	DCHMC	0		88.00
88.01	08801	NDMC/ODON	0		88.01
88.02	08802	QUICK CARE	0		88.02
88.04	08803	PEDIATRICS	0		88.04
88.05	08804	DAVIESS MARTIN	0		88.05
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	2,170		93.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
101.00	10100	HOME HEALTH AGENCY	1,962		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	2,943		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,279		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07951	OTHER NONREIMBURSABLE AND PHYSICIAN	0		194.00
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)	136,225		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.714796		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,512		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.757247		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 12:29 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,368,149		4,368,149	0	4,368,149	30.00
31.00	03100	INTENSIVE CARE UNIT	1,438,693		1,438,693	0	1,438,693	31.00
40.00	04000	SUBPROVIDER - IPF	4,282,152		4,282,152	0	4,282,152	40.00
41.00	04100	SUBPROVIDER - IRF	2,617,629		2,617,629	0	2,617,629	41.00
43.00	04300	NURSERY	514,801		514,801	0	514,801	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,952,872		1,952,872	0	1,952,872	50.00
51.00	05100	RECOVERY ROOM	90,087		90,087	0	90,087	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	865,319		865,319	0	865,319	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,870,407		2,870,407	0	2,870,407	54.00
56.00	05600	RADIOISOTOPE	898,559		898,559	0	898,559	56.00
60.00	06000	LABORATORY	3,645,541		3,645,541	0	3,645,541	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	424,007		424,007	0	424,007	63.00
64.00	06400	INTRAVENOUS THERAPY	74,357		74,357	0	74,357	64.00
65.00	06500	RESPIRATORY THERAPY	1,207,890	0	1,207,890	0	1,207,890	65.00
66.00	06600	PHYSICAL THERAPY	1,390,999	0	1,390,999	0	1,390,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	485,520	0	485,520	0	485,520	67.00
68.00	06800	SPEECH PATHOLOGY	193,958	0	193,958	0	193,958	68.00
69.00	06900	ELECTROCARDIOLOGY	172,458		172,458	0	172,458	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,450,752		2,450,752	0	2,450,752	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	598,917		598,917	0	598,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,493,287		3,493,287	0	3,493,287	73.00
76.00	03020	CARDIAC REHAB	178,925		178,925	0	178,925	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	1,433,185		1,433,185	0	1,433,185	88.00
88.01	08801	NDMC/ODON	1,581,636		1,581,636	0	1,581,636	88.01
88.02	08802	QUICK CARE	1,282,258		1,282,258	0	1,282,258	88.02
88.04	08803	PEDIATRICS	1,015,427		1,015,427	0	1,015,427	88.04
88.05	08804	DAVIESS MARTIN	1,037,024		1,037,024	0	1,037,024	88.05
90.00	09000	CLINIC	585,778		585,778	0	585,778	90.00
91.00	09100	EMERGENCY	3,275,941		3,275,941	0	3,275,941	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,218,482		1,218,482		1,218,482	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	571,797		571,797	0	571,797	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	432,413		432,413		432,413	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	826,201		826,201		826,201	116.00
200.00		Subtotal (see instructions)	47,475,421	0	47,475,421	0	47,475,421	200.00
201.00		Less Observation Beds	1,218,482		1,218,482		1,218,482	201.00
202.00		Total (see instructions)	46,256,939	0	46,256,939	0	46,256,939	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,486,552		3,486,552			30.00
31.00	03100	INTENSIVE CARE UNIT	2,634,741		2,634,741			31.00
40.00	04000	SUBPROVIDER - IPF	8,008,259		8,008,259			40.00
41.00	04100	SUBPROVIDER - IRF	2,903,211		2,903,211			41.00
43.00	04300	NURSERY	635,162		635,162			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,303,446	4,915,327	6,218,773	0.314029	0.000000	50.00
51.00	05100	RECOVERY ROOM	125,870	590,430	716,300	0.125767	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	575,586	80,345	655,931	1.319223	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,273,263	12,521,918	14,795,181	0.194010	0.000000	54.00
56.00	05600	RADIOISOTOPE	608,175	3,821,635	4,429,810	0.202844	0.000000	56.00
60.00	06000	LABORATORY	4,451,562	15,157,210	19,608,772	0.185914	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	491,601	420,101	911,702	0.465072	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	382,012	372,058	754,070	0.098608	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,938,905	1,364,898	3,303,803	0.365606	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	895,774	1,896,283	2,792,057	0.498199	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	690,849	625,625	1,316,474	0.368803	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	112,021	176,449	288,470	0.672368	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	347,429	827,822	1,175,251	0.146741	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,487,351	2,678,776	4,166,127	0.588257	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	383,207	329,388	712,595	0.840473	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,751,151	2,355,810	7,106,961	0.491530	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	81,742	81,742	2.188899	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	1,474,714	1,474,714			88.00
88.01	08801	NDMC/ODON	0	1,326,840	1,326,840			88.01
88.02	08802	QUICK CARE	0	1,465,431	1,465,431			88.02
88.04	08803	PEDIATRICS	0	1,240,873	1,240,873			88.04
88.05	08804	DAVIESS MARTIN	0	1,066,618	1,066,618			88.05
90.00	09000	CLINIC	34,500	1,789,324	1,823,824	0.321181	0.000000	90.00
91.00	09100	EMERGENCY	1,254,660	6,359,262	7,613,922	0.430257	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	167,636	880,088	1,047,724	1.162980	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	3,200	1,092,854	1,096,054	0.521687	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	162,582	162,582			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	846,110	846,110			116.00
200.00		Subtotal (see instructions)	39,946,123	65,920,513	105,866,636			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,946,123	65,920,513	105,866,636			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 12:29 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
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.314029	50.00
51.00	05100	RECOVERY ROOM	0.125767	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	54.00
56.00	05600	RADIOISOTOPE	0.202844	56.00
60.00	06000	LABORATORY	0.185914	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	73.00
76.00	03020	CARDIAC REHAB	2.188899	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	DCHMC		88.00
88.01	08801	NDMC/ODON		88.01
88.02	08802	QUICK CARE		88.02
88.04	08803	PEDIATRICS		88.04
88.05	08804	DAVIESS MARTIN		88.05
90.00	09000	CLINIC	0.321181	90.00
91.00	09100	EMERGENCY	0.430257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	93.00
		OTHER REIMBURSABLE COST CENTERS		
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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 12:29 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,368,149		4,368,149	0	4,368,149	30.00
31.00	03100	INTENSIVE CARE UNIT	1,438,693		1,438,693	0	1,438,693	31.00
40.00	04000	SUBPROVIDER - IPF	4,282,152		4,282,152	0	4,282,152	40.00
41.00	04100	SUBPROVIDER - IRF	2,617,629		2,617,629	0	2,617,629	41.00
43.00	04300	NURSERY	514,801		514,801	0	514,801	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,952,872		1,952,872	0	1,952,872	50.00
51.00	05100	RECOVERY ROOM	90,087		90,087	0	90,087	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	865,319		865,319	0	865,319	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,870,407		2,870,407	0	2,870,407	54.00
56.00	05600	RADIOISOTOPE	898,559		898,559	0	898,559	56.00
60.00	06000	LABORATORY	3,645,541		3,645,541	0	3,645,541	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	424,007		424,007	0	424,007	63.00
64.00	06400	INTRAVENOUS THERAPY	74,357		74,357	0	74,357	64.00
65.00	06500	RESPIRATORY THERAPY	1,207,890	0	1,207,890	0	1,207,890	65.00
66.00	06600	PHYSICAL THERAPY	1,390,999	0	1,390,999	0	1,390,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	485,520	0	485,520	0	485,520	67.00
68.00	06800	SPEECH PATHOLOGY	193,958	0	193,958	0	193,958	68.00
69.00	06900	ELECTROCARDIOLOGY	172,458		172,458	0	172,458	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,450,752		2,450,752	0	2,450,752	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	598,917		598,917	0	598,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,493,287		3,493,287	0	3,493,287	73.00
76.00	03020	CARDIAC REHAB	178,925		178,925	0	178,925	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	1,433,185		1,433,185	0	1,433,185	88.00
88.01	08801	NDMC/ODON	1,581,636		1,581,636	0	1,581,636	88.01
88.02	08802	QUICK CARE	1,282,258		1,282,258	0	1,282,258	88.02
88.04	08803	PEDIATRICS	1,015,427		1,015,427	0	1,015,427	88.04
88.05	08804	DAVIESS MARTIN	1,037,024		1,037,024	0	1,037,024	88.05
90.00	09000	CLINIC	585,778		585,778	0	585,778	90.00
91.00	09100	EMERGENCY	3,275,941		3,275,941	0	3,275,941	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,218,482		1,218,482		1,218,482	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	571,797		571,797	0	571,797	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	432,413		432,413		432,413	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	826,201		826,201		826,201	116.00
200.00		Subtotal (see instructions)	47,475,421	0	47,475,421	0	47,475,421	200.00
201.00		Less Observation Beds	1,218,482		1,218,482		1,218,482	201.00
202.00		Total (see instructions)	46,256,939	0	46,256,939	0	46,256,939	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 12:29 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,486,552		3,486,552			30.00
31.00	03100	INTENSIVE CARE UNIT	2,634,741		2,634,741			31.00
40.00	04000	SUBPROVIDER - IPF	8,008,259		8,008,259			40.00
41.00	04100	SUBPROVIDER - IRF	2,903,211		2,903,211			41.00
43.00	04300	NURSERY	635,162		635,162			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,303,446	4,915,327	6,218,773	0.314029	0.000000	50.00
51.00	05100	RECOVERY ROOM	125,870	590,430	716,300	0.125767	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	575,586	80,345	655,931	1.319223	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,273,263	12,521,918	14,795,181	0.194010	0.000000	54.00
56.00	05600	RADIOISOTOPE	608,175	3,821,635	4,429,810	0.202844	0.000000	56.00
60.00	06000	LABORATORY	4,451,562	15,157,210	19,608,772	0.185914	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	491,601	420,101	911,702	0.465072	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	382,012	372,058	754,070	0.098608	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,938,905	1,364,898	3,303,803	0.365606	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	895,774	1,896,283	2,792,057	0.498199	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	690,849	625,625	1,316,474	0.368803	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	112,021	176,449	288,470	0.672368	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	347,429	827,822	1,175,251	0.146741	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,487,351	2,678,776	4,166,127	0.588257	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	383,207	329,388	712,595	0.840473	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,751,151	2,355,810	7,106,961	0.491530	0.000000	73.00
76.00	03020	CARDIAC REHAB	0	81,742	81,742	2.188899	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	1,474,714	1,474,714	0.971839	0.000000	88.00
88.01	08801	NDMC/ODON	0	1,326,840	1,326,840	1.192032	0.000000	88.01
88.02	08802	QUICK CARE	0	1,465,431	1,465,431	0.875004	0.000000	88.02
88.04	08803	PEDIATRICS	0	1,240,873	1,240,873	0.818317	0.000000	88.04
88.05	08804	DAVIESS MARTIN	0	1,066,618	1,066,618	0.972254	0.000000	88.05
90.00	09000	CLINIC	34,500	1,789,324	1,823,824	0.321181	0.000000	90.00
91.00	09100	EMERGENCY	1,254,660	6,359,262	7,613,922	0.430257	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	167,636	880,088	1,047,724	1.162980	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	3,200	1,092,854	1,096,054	0.521687	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	162,582	162,582			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	846,110	846,110			116.00
200.00		Subtotal (see instructions)	39,946,123	65,920,513	105,866,636			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	39,946,123	65,920,513	105,866,636			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/21/2015 12:29 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
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	DCHMC	0.000000		88.00
88.01	08801	NDMC/ODON	0.000000		88.01
88.02	08802	QUICK CARE	0.000000		88.02
88.04	08803	PEDIATRICS	0.000000		88.04
88.05	08804	DAVIESS MARTIN	0.000000		88.05
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/21/2015 12:29 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	332,395	0	332,395	5,130	64.79	30.00
31.00	INTENSIVE CARE UNIT	98,669		98,669	871	113.28	31.00
40.00	SUBPROVIDER - IPF	360,039	0	360,039	5,874	61.29	40.00
41.00	SUBPROVIDER - IRF	228,744	0	228,744	2,539	90.09	41.00
43.00	NURSERY	34,916		34,916	835	41.82	43.00
200.00	Total (lines 30-199)	1,054,763		1,054,763	15,249		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	1,784	115,585				30.00
31.00	INTENSIVE CARE UNIT	501	56,753				31.00
40.00	SUBPROVIDER - IPF	5,021	307,737				40.00
41.00	SUBPROVIDER - IRF	2,045	184,234				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	9,351	664,309				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/21/2015 12:29 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	274,801	6,218,773	0.044189	497,243	21,973	50.00
51.00	05100	RECOVERY ROOM	29,334	716,300	0.040952	48,974	2,006	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	168,011	655,931	0.256141	4,221	1,081	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,495	14,795,181	0.020581	1,182,960	24,346	54.00
56.00	05600	RADIOISOTOPE	79,250	4,429,810	0.017890	376,573	6,737	56.00
60.00	06000	LABORATORY	229,959	19,608,772	0.011727	1,902,119	22,306	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	26,520	911,702	0.029088	177,522	5,164	63.00
64.00	06400	INTRAVENOUS THERAPY	17,645	754,070	0.023400	181,858	4,255	64.00
65.00	06500	RESPIRATORY THERAPY	85,688	3,303,803	0.025936	755,851	19,604	65.00
66.00	06600	PHYSICAL THERAPY	100,725	2,792,057	0.036076	76,771	2,770	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,893	1,316,474	0.022707	30,102	684	67.00
68.00	06800	SPEECH PATHOLOGY	15,695	288,470	0.054408	14,839	807	68.00
69.00	06900	ELECTROCARDIOLOGY	21,772	1,175,251	0.018525	139,160	2,578	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,407	4,166,127	0.032022	625,385	20,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,972	712,595	0.033640	264,253	8,889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255,546	7,106,961	0.035957	1,089,662	39,181	73.00
76.00	03020	CARDIAC REHAB	36,361	81,742	0.444826	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	119,318	1,474,714	0.080909	0	0	88.00
88.01	08801	NDMC/ODON	116,748	1,326,840	0.087990	0	0	88.01
88.02	08802	QUICK CARE	119,856	1,465,431	0.081789	0	0	88.02
88.04	08803	PEDIATRICS	65,828	1,240,873	0.053050	0	0	88.04
88.05	08804	DAVIESS MARTIN	94,667	1,066,618	0.088754	0	0	88.05
90.00	09000	CLINIC	79,034	1,823,824	0.043334	34,498	1,495	90.00
91.00	09100	EMERGENCY	250,631	7,613,922	0.032917	615,834	20,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92,720	1,047,724	0.088497	120,737	10,685	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	97,811	1,096,054	0.089239	574	51	93.00
200.00		Total (lines 50-199)	2,869,687	87,190,019		8,139,136	214,909	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/21/2015 12:29 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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,130	0.00	1,784	0		30.00
31.00	03100	INTENSIVE CARE UNIT	871	0.00	501	0		31.00
40.00	04000	SUBPROVIDER - IPF	5,874	0.00	5,021	0		40.00
41.00	04100	SUBPROVIDER - IRF	2,539	0.00	2,045	0		41.00
43.00	04300	NURSERY	835	0.00	0	0		43.00
200.00		Total (lines 30-199)	15,249		9,351	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 12:29 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	0	0	0	0	88.00
88.01	08801	NDMC/ODON	0	0	0	0	0	88.01
88.02	08802	QUICK CARE	0	0	0	0	0	88.02
88.04	08803	PEDIATRICS	0	0	0	0	0	88.04
88.05	08804	DAVIESS MARTIN	0	0	0	0	0	88.05
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 PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/21/2015 12:29 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	6,218,773	0.000000	0.000000	497,243	50.00
51.00	05100	RECOVERY ROOM	0	716,300	0.000000	0.000000	48,974	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	655,931	0.000000	0.000000	4,221	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,795,181	0.000000	0.000000	1,182,960	54.00
56.00	05600	RADIOISOTOPE	0	4,429,810	0.000000	0.000000	376,573	56.00
60.00	06000	LABORATORY	0	19,608,772	0.000000	0.000000	1,902,119	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	911,702	0.000000	0.000000	177,522	63.00
64.00	06400	INTRAVENOUS THERAPY	0	754,070	0.000000	0.000000	181,858	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,303,803	0.000000	0.000000	755,851	65.00
66.00	06600	PHYSICAL THERAPY	0	2,792,057	0.000000	0.000000	76,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,316,474	0.000000	0.000000	30,102	67.00
68.00	06800	SPEECH PATHOLOGY	0	288,470	0.000000	0.000000	14,839	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,175,251	0.000000	0.000000	139,160	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,166,127	0.000000	0.000000	625,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	712,595	0.000000	0.000000	264,253	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,106,961	0.000000	0.000000	1,089,662	73.00
76.00	03020	CARDIAC REHAB	0	81,742	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	1,474,714	0.000000	0.000000	0	88.00
88.01	08801	NDMC/ODON	0	1,326,840	0.000000	0.000000	0	88.01
88.02	08802	QUICK CARE	0	1,465,431	0.000000	0.000000	0	88.02
88.04	08803	PEDIATRICS	0	1,240,873	0.000000	0.000000	0	88.04
88.05	08804	DAVIESS MARTIN	0	1,066,618	0.000000	0.000000	0	88.05
90.00	09000	CLINIC	0	1,823,824	0.000000	0.000000	34,498	90.00
91.00	09100	EMERGENCY	0	7,613,922	0.000000	0.000000	615,834	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,047,724	0.000000	0.000000	120,737	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	1,096,054	0.000000	0.000000	574	93.00
200.00		Total (lines 50-199)	0	87,190,019			8,139,136	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/21/2015 12:29 pm

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,655,053	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,573,612	0		54.00
56.00	05600	RADIOISOTOPE	0	1,458,119	0		56.00
60.00	06000	LABORATORY	0	1,775,470	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	198,626	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	111,550	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	528,683	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	8,653	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	231,594	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	821,054	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	130,261	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,205,111	0		73.00
76.00	03020	CARDIAC REHAB	0	43,243	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	DCHMC	0	0	0		88.00
88.01	08801	NDMC/ODON	0	0	0		88.01
88.02	08802	QUICK CARE	0	0	0		88.02
88.04	08803	PEDIATRICS	0	0	0		88.04
88.05	08804	DAVIESS MARTIN	0	0	0		88.05
90.00	09000	CLINIC	0	901,955	0		90.00
91.00	09100	EMERGENCY	0	1,307,903	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	272,297	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	585,808	0		93.00
200.00		Total (lines 50-199)	0	14,808,992	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.314029	1,655,053	0	0	519,735	50.00
51.00	05100	RECOVERY ROOM	0.125767	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	3,573,612	0	0	693,316	54.00
56.00	05600	RADIOISOTOPE	0.202844	1,458,119	0	0	295,771	56.00
60.00	06000	LABORATORY	0.185914	1,775,470	0	0	330,085	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	198,626	0	0	92,375	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	111,550	0	0	11,000	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	528,683	0	0	193,290	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	8,653	0	0	5,818	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	231,594	0	0	33,984	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	821,054	0	0	482,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	130,261	0	0	109,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	1,205,111	0	795	592,348	73.00
76.00	03020	CARDIAC REHAB	2.188899	43,243	0	0	94,655	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0.000000				0	88.00
88.01	08801	NDMC/ODON	0.000000				0	88.01
88.02	08802	QUICK CARE	0.000000				0	88.02
88.04	08803	PEDIATRICS	0.000000				0	88.04
88.05	08804	DAVIESS MARTIN	0.000000				0	88.05
90.00	09000	CLINIC	0.321181	901,955	0	0	289,691	90.00
91.00	09100	EMERGENCY	0.430257	1,307,903	0	0	562,734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	272,297	0	0	316,676	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	585,808	0	0	305,608	93.00
200.00		Subtotal (see instructions)		14,808,992	0	795	4,929,558	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		14,808,992	0	795	4,929,558	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	391		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0	0		88.00
88.01	08801	NDMC/ODON	0	0		88.01
88.02	08802	QUICK CARE	0	0		88.02
88.04	08803	PEDIATRICS	0	0		88.04
88.05	08804	DAVIESS MARTIN	0	0		88.05
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
200.00		Subtotal (see instructions)	0	391		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	391		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150061 | Component CCN: 15S061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	274,801	6,218,773	0.044189	4,912	217	50.00
51.00	05100	RECOVERY ROOM	29,334	716,300	0.040952	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	168,011	655,931	0.256141	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,495	14,795,181	0.020581	141,113	2,904	54.00
56.00	05600	RADIOISOTOPE	79,250	4,429,810	0.017890	29,962	536	56.00
60.00	06000	LABORATORY	229,959	19,608,772	0.011727	775,642	9,096	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	26,520	911,702	0.029088	22,011	640	63.00
64.00	06400	INTRAVENOUS THERAPY	17,645	754,070	0.023400	7,918	185	64.00
65.00	06500	RESPIRATORY THERAPY	85,688	3,303,803	0.025936	200,105	5,190	65.00
66.00	06600	PHYSICAL THERAPY	100,725	2,792,057	0.036076	30,087	1,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,893	1,316,474	0.022707	4,252	97	67.00
68.00	06800	SPEECH PATHOLOGY	15,695	288,470	0.054408	10,798	587	68.00
69.00	06900	ELECTROCARDIOLOGY	21,772	1,175,251	0.018525	45,016	834	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,407	4,166,127	0.032022	78,086	2,500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,972	712,595	0.033640	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255,546	7,106,961	0.035957	1,761,356	63,333	73.00
76.00	03020	CARDIAC REHAB	36,361	81,742	0.444826	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	119,318	1,474,714	0.080909	0	0	88.00
88.01	08801	NDMC/ODON	116,748	1,326,840	0.087990	0	0	88.01
88.02	08802	QUICK CARE	119,856	1,465,431	0.081789	0	0	88.02
88.04	08803	PEDIATRICS	65,828	1,240,873	0.053050	0	0	88.04
88.05	08804	DAVIESS MARTIN	94,667	1,066,618	0.088754	0	0	88.05
90.00	09000	CLINIC	79,034	1,823,824	0.043334	0	0	90.00
91.00	09100	EMERGENCY	250,631	7,613,922	0.032917	193,234	6,361	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,047,724	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	97,811	1,096,054	0.089239	2,582	230	93.00
200.00		Total (lines 50-199)	2,776,967	87,190,019		3,307,074	93,795	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150061 Component CCN: 15S061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	0	0	0	0	88.00
88.01	08801	NDMC/ODON	0	0	0	0	0	88.01
88.02	08802	QUICK CARE	0	0	0	0	0	88.02
88.04	08803	PEDIATRICS	0	0	0	0	0	88.04
88.05	08804	DAVIESS MARTIN	0	0	0	0	0	88.05
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 PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
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: 150061 | Component CCN: 15S061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,218,773	0.000000	0.000000	4,912	50.00
51.00	05100	RECOVERY ROOM	0	716,300	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	655,931	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,795,181	0.000000	0.000000	141,113	54.00
56.00	05600	RADIOISOTOPE	0	4,429,810	0.000000	0.000000	29,962	56.00
60.00	06000	LABORATORY	0	19,608,772	0.000000	0.000000	775,642	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	911,702	0.000000	0.000000	22,011	63.00
64.00	06400	INTRAVENOUS THERAPY	0	754,070	0.000000	0.000000	7,918	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,303,803	0.000000	0.000000	200,105	65.00
66.00	06600	PHYSICAL THERAPY	0	2,792,057	0.000000	0.000000	30,087	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,316,474	0.000000	0.000000	4,252	67.00
68.00	06800	SPEECH PATHOLOGY	0	288,470	0.000000	0.000000	10,798	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,175,251	0.000000	0.000000	45,016	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,166,127	0.000000	0.000000	78,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	712,595	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,106,961	0.000000	0.000000	1,761,356	73.00
76.00	03020	CARDIAC REHAB	0	81,742	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	1,474,714	0.000000	0.000000	0	88.00
88.01	08801	NDMC/ODON	0	1,326,840	0.000000	0.000000	0	88.01
88.02	08802	QUICK CARE	0	1,465,431	0.000000	0.000000	0	88.02
88.04	08803	PEDIATRICS	0	1,240,873	0.000000	0.000000	0	88.04
88.05	08804	DAVIESS MARTIN	0	1,066,618	0.000000	0.000000	0	88.05
90.00	09000	CLINIC	0	1,823,824	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	7,613,922	0.000000	0.000000	193,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,047,724	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	1,096,054	0.000000	0.000000	2,582	93.00
200.00		Total (lines 50-199)	0	87,190,019			3,307,074	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150061 | Component CCN: 15S061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	DCHMC	0	0	0		88.00
88.01	08801	NDMC/ODON	0	0	0		88.01
88.02	08802	QUICK CARE	0	0	0		88.02
88.04	08803	PEDIATRICS	0	0	0		88.04
88.05	08804	DAVIESS MARTIN	0	0	0		88.05
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150061 | Component CCN: 15T061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	274,801	6,218,773	0.044189	1,150	51	50.00
51.00	05100	RECOVERY ROOM	29,334	716,300	0.040952	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	168,011	655,931	0.256141	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,495	14,795,181	0.020581	62,255	1,281	54.00
56.00	05600	RADIOISOTOPE	79,250	4,429,810	0.017890	12,013	215	56.00
60.00	06000	LABORATORY	229,959	19,608,772	0.011727	224,967	2,638	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	26,520	911,702	0.029088	22,540	656	63.00
64.00	06400	INTRAVENOUS THERAPY	17,645	754,070	0.023400	5,999	140	64.00
65.00	06500	RESPIRATORY THERAPY	85,688	3,303,803	0.025936	153,702	3,986	65.00
66.00	06600	PHYSICAL THERAPY	100,725	2,792,057	0.036076	601,586	21,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,893	1,316,474	0.022707	505,760	11,484	67.00
68.00	06800	SPEECH PATHOLOGY	15,695	288,470	0.054408	59,726	3,250	68.00
69.00	06900	ELECTROCARDIOLOGY	21,772	1,175,251	0.018525	2,859	53	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,407	4,166,127	0.032022	150,780	4,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	23,972	712,595	0.033640	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255,546	7,106,961	0.035957	534,593	19,222	73.00
76.00	03020	CARDIAC REHAB	36,361	81,742	0.444826	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	119,318	1,474,714	0.080909	0	0	88.00
88.01	08801	NDMC/ODON	116,748	1,326,840	0.087990	0	0	88.01
88.02	08802	QUICK CARE	119,856	1,465,431	0.081789	0	0	88.02
88.04	08803	PEDIATRICS	65,828	1,240,873	0.053050	0	0	88.04
88.05	08804	DAVIESS MARTIN	94,667	1,066,618	0.088754	0	0	88.05
90.00	09000	CLINIC	79,034	1,823,824	0.043334	0	0	90.00
91.00	09100	EMERGENCY	250,631	7,613,922	0.032917	8,205	270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,047,724	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	97,811	1,096,054	0.089239	0	0	93.00
200.00		Total (lines 50-199)	2,776,967	87,190,019		2,346,135	69,777	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150061 | Component CCN: 15T061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	0	0	0	0	88.00
88.01	08801	NDMC/ODON	0	0	0	0	0	88.01
88.02	08802	QUICK CARE	0	0	0	0	0	88.02
88.04	08803	PEDIATRICS	0	0	0	0	0	88.04
88.05	08804	DAVIESS MARTIN	0	0	0	0	0	88.05
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 PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
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: 150061 | Component CCN: 15T061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,218,773	0.000000	0.000000	1,150	50.00
51.00	05100	RECOVERY ROOM	0	716,300	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	655,931	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,795,181	0.000000	0.000000	62,255	54.00
56.00	05600	RADIOISOTOPE	0	4,429,810	0.000000	0.000000	12,013	56.00
60.00	06000	LABORATORY	0	19,608,772	0.000000	0.000000	224,967	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	911,702	0.000000	0.000000	22,540	63.00
64.00	06400	INTRAVENOUS THERAPY	0	754,070	0.000000	0.000000	5,999	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,303,803	0.000000	0.000000	153,702	65.00
66.00	06600	PHYSICAL THERAPY	0	2,792,057	0.000000	0.000000	601,586	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,316,474	0.000000	0.000000	505,760	67.00
68.00	06800	SPEECH PATHOLOGY	0	288,470	0.000000	0.000000	59,726	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,175,251	0.000000	0.000000	2,859	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,166,127	0.000000	0.000000	150,780	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	712,595	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,106,961	0.000000	0.000000	534,593	73.00
76.00	03020	CARDIAC REHAB	0	81,742	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0	1,474,714	0.000000	0.000000	0	88.00
88.01	08801	NDMC/ODON	0	1,326,840	0.000000	0.000000	0	88.01
88.02	08802	QUICK CARE	0	1,465,431	0.000000	0.000000	0	88.02
88.04	08803	PEDIATRICS	0	1,240,873	0.000000	0.000000	0	88.04
88.05	08804	DAVIESS MARTIN	0	1,066,618	0.000000	0.000000	0	88.05
90.00	09000	CLINIC	0	1,823,824	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	7,613,922	0.000000	0.000000	8,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,047,724	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	1,096,054	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	87,190,019			2,346,135	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150061 | Component CCN: 15T061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	DCHMC	0	0	0		88.00
88.01	08801	NDMC/ODON	0	0	0		88.01
88.02	08802	QUICK CARE	0	0	0		88.02
88.04	08803	PEDIATRICS	0	0	0		88.04
88.05	08804	DAVIESS MARTIN	0	0	0		88.05
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 12:29 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.314029	0	926,865	0	0	50.00
51.00	05100	RECOVERY ROOM	0.125767	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	0	51,046	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	0	2,259,355	0	0	54.00
56.00	05600	RADIOISOTOPE	0.202844	0	477,601	0	0	56.00
60.00	06000	LABORATORY	0.185914	0	2,162,254	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	0	26,467	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	0	69,863	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	0	281,458	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	0	245,839	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	0	76,960	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	0	60,227	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	0	115,974	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	0	517,740	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	0	276,041	0	0	73.00
76.00	03020	CARDIAC REHAB	2.188899	0	753	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	DCHMC	0.971839				0	88.00
88.01	08801	NDMC/ODON	1.192032				0	88.01
88.02	08802	QUICK CARE	0.875004				0	88.02
88.04	08803	PEDIATRICS	0.818317				0	88.04
88.05	08804	DAVIESS MARTIN	0.972254				0	88.05
90.00	09000	CLINIC	0.321181	0	232,196	0	0	90.00
91.00	09100	EMERGENCY	0.430257	0	1,677,872	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	0	18,533	0	0	93.00
200.00		Subtotal (see instructions)		0	9,477,044	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	9,477,044	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/21/2015 12:29 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	291,062	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67,341	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	438,337	0		54.00
56.00	05600	RADIOISOTOPE	96,878	0		56.00
60.00	06000	LABORATORY	401,993	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,309	0		63.00
64.00	06400	INTRAVENOUS THERAPY	6,889	0		64.00
65.00	06500	RESPIRATORY THERAPY	102,903	0		65.00
66.00	06600	PHYSICAL THERAPY	122,477	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,383	0		67.00
68.00	06800	SPEECH PATHOLOGY	40,495	0		68.00
69.00	06900	ELECTROCARDIOLOGY	17,018	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	304,564	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,682	0		73.00
76.00	03020	CARDIAC REHAB	1,648	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0	0		88.00
88.01	08801	NDMC/ODON	0	0		88.01
88.02	08802	QUICK CARE	0	0		88.02
88.04	08803	PEDIATRICS	0	0		88.04
88.05	08804	DAVIESS MARTIN	0	0		88.05
90.00	09000	CLINIC	74,577	0		90.00
91.00	09100	EMERGENCY	721,916	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	9,668	0		93.00
200.00		Subtotal (see instructions)	2,874,140	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,874,140	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,130	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,130	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)	3,699	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)	1,784	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,368,149	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,368,149	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,368,149	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)	851.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,519,058	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)	1,519,058	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,438,693	871	1,651.77	501	827,537	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)	2,826,331	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,172,926	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)	172,338	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	214,909	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	387,247	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,785,679	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,431	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	851.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,218,482	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	332,395	4,368,149	0.076095	1,218,482	92,720	90.00
91.00	Nursing School cost	0	4,368,149	0.000000	1,218,482	0	91.00
92.00	Allied health cost	0	4,368,149	0.000000	1,218,482	0	92.00
93.00	All other Medical Education	0	4,368,149	0.000000	1,218,482	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150061	Period: From 01/01/2014	Worksheet D-1
Component CCN: 15S061	To 12/31/2014	Date/Time Prepared: 5/21/2015 12:29 pm
Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,874	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,874	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,874	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)	5,021	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,282,152	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,282,152	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,282,152	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)	729.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,660,309	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)	3,660,309	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150061 | Component CCN: 15S061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,289,983	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,950,292	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)	307,737	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	93,795	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	401,532	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,548,760	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 15S061 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	360,039	4,282,152	0.084079	0	0	90.00
91.00	Nursing School cost	0	4,282,152	0.000000	0	0	91.00
92.00	Allied health cost	0	4,282,152	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,282,152	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150061	Period: From 01/01/2014	Worksheet D-1
Component CCN: 15T061	To 12/31/2014	Date/Time Prepared: 5/21/2015 12:29 pm
Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,539	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,539	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)	2,539	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)	2,045	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)	2,617,629	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)	2,617,629	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)	2,617,629	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,030.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,108,334	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,108,334	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150061 | Component CCN: 15T061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,005,779	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,114,113	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)	184,234	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	69,777	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	254,011	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,860,102	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 15T061 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	228,744	2,617,629	0.087386	0	0	90.00
91.00	Nursing School cost	0	2,617,629	0.000000	0	0	91.00
92.00	Allied health cost	0	2,617,629	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,617,629	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 12:29 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		782,916		30.00
31.00	03100	INTENSIVE CARE UNIT		1,548,930		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		42,607		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314029	497,243	156,149	50.00
51.00	05100	RECOVERY ROOM	0.125767	48,974	6,159	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	4,221	5,568	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	1,182,960	229,506	54.00
56.00	05600	RADIOISOTOPE	0.202844	376,573	76,386	56.00
60.00	06000	LABORATORY	0.185914	1,902,119	353,631	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	177,522	82,561	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	181,858	17,933	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	755,851	276,344	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	76,771	38,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	30,102	11,102	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	14,839	9,977	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	139,160	20,420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	625,385	367,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	264,253	222,098	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	1,089,662	535,602	73.00
76.00	03020	CARDIAC REHAB	2.188899	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0.000000		0	88.00
88.01	08801	NDMC/ODON	0.000000		0	88.01
88.02	08802	QUICK CARE	0.000000		0	88.02
88.04	08803	PEDIATRICS	0.000000		0	88.04
88.05	08804	DAVIESS MARTIN	0.000000		0	88.05
90.00	09000	CLINIC	0.321181	34,498	11,080	90.00
91.00	09100	EMERGENCY	0.430257	615,834	264,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	120,737	140,415	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	574	299	93.00
200.00		Total (sum of lines 50-94 and 96-98)		8,139,136	2,826,331	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		8,139,136		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150061 | Component CCN: 15S061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		6,054,599		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314029	4,912	1,543	50.00
51.00	05100	RECOVERY ROOM	0.125767	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	141,113	27,377	54.00
56.00	05600	RADIOISOTOPE	0.202844	29,962	6,078	56.00
60.00	06000	LABORATORY	0.185914	775,642	144,203	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	22,011	10,237	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	7,918	781	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	200,105	73,160	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	30,087	14,989	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	4,252	1,568	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	10,798	7,260	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	45,016	6,606	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	78,086	45,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	1,761,356	865,759	73.00
76.00	03020	CARDIAC REHAB	2.188899	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0.000000		0	88.00
88.01	08801	NDMC/ODON	0.000000		0	88.01
88.02	08802	QUICK CARE	0.000000		0	88.02
88.04	08803	PEDIATRICS	0.000000		0	88.04
88.05	08804	DAVIESS MARTIN	0.000000		0	88.05
90.00	09000	CLINIC	0.321181	0	0	90.00
91.00	09100	EMERGENCY	0.430257	193,234	83,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	2,582	1,347	93.00
200.00		Total (sum of lines 50-94 and 96-98)		3,307,074	1,289,983	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)		3,307,074		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 15T061 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		2,211,387		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314029	1,150	361	50.00
51.00	05100	RECOVERY ROOM	0.125767	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	62,255	12,078	54.00
56.00	05600	RADIOISOTOPE	0.202844	12,013	2,437	56.00
60.00	06000	LABORATORY	0.185914	224,967	41,825	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	22,540	10,483	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	5,999	592	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	153,702	56,194	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	601,586	299,710	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	505,760	186,526	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	59,726	40,158	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	2,859	420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	150,780	88,697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	534,593	262,768	73.00
76.00	03020	CARDIAC REHAB	2.188899	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0.000000		0	88.00
88.01	08801	NDMC/ODON	0.000000		0	88.01
88.02	08802	QUICK CARE	0.000000		0	88.02
88.04	08803	PEDIATRICS	0.000000		0	88.04
88.05	08804	DAVIESS MARTIN	0.000000		0	88.05
90.00	09000	CLINIC	0.321181	0	0	90.00
91.00	09100	EMERGENCY	0.430257	8,205	3,530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		2,346,135	1,005,779	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)		2,346,135		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 12:29 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		1,153,656		30.00
31.00	03100	INTENSIVE CARE UNIT		252,403		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		253,553		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314029	337,081	105,853	50.00
51.00	05100	RECOVERY ROOM	0.125767	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	197,549	260,611	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	265,008	51,414	54.00
56.00	05600	RADIOISOTOPE	0.202844	60,279	12,227	56.00
60.00	06000	LABORATORY	0.185914	509,253	94,677	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	63,597	29,577	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	65,451	6,454	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	146,898	53,707	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	35,512	17,692	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	25,187	9,289	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	4,999	3,361	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	26,976	3,958	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	318,339	187,265	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	484,461	238,127	73.00
76.00	03020	CARDIAC REHAB	2.188899	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0.971839	0	0	88.00
88.01	08801	NDMC/ODON	1.192032	0	0	88.01
88.02	08802	QUICK CARE	0.875004	0	0	88.02
88.04	08803	PEDIATRICS	0.818317	0	0	88.04
88.05	08804	DAVIESS MARTIN	0.972254	0	0	88.05
90.00	09000	CLINIC	0.321181	0	0	90.00
91.00	09100	EMERGENCY	0.430257	154,223	66,356	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		2,694,813	1,140,568	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)		2,694,813		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 15S061 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XIX | Subprovider - IPF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		373,598		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314029	37	12	50.00
51.00	05100	RECOVERY ROOM	0.125767	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	7,558	1,466	54.00
56.00	05600	RADIOISOTOPE	0.202844	1,026	208	56.00
60.00	06000	LABORATORY	0.185914	42,721	7,942	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	209	97	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	276	27	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	11,958	4,372	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	1,908	951	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	247	91	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	593	399	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	3,245	476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	2,094	1,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	97,836	48,089	73.00
76.00	03020	CARDIAC REHAB	2.188899	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0.971839	0	0	88.00
88.01	08801	NDMC/ODON	1.192032	0	0	88.01
88.02	08802	QUICK CARE	0.875004	0	0	88.02
88.04	08803	PEDIATRICS	0.818317	0	0	88.04
88.05	08804	DAVIESS MARTIN	0.972254	0	0	88.05
90.00	09000	CLINIC	0.321181	0	0	90.00
91.00	09100	EMERGENCY	0.430257	9,740	4,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	35	18	93.00
200.00		Total (sum of lines 50-94 and 96-98)		179,483	69,571	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)		179,483		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150061 | Component CCN: 15T061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XIX | Subprovider - IRF | 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		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		123		40.00
41.00	04100	SUBPROVIDER - IRF		140,473		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314029	97	30	50.00
51.00	05100	RECOVERY ROOM	0.125767	19	2	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.319223	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.194010	2,792	542	54.00
56.00	05600	RADIOISOTOPE	0.202844	399	81	56.00
60.00	06000	LABORATORY	0.185914	12,381	2,302	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.465072	1,310	609	63.00
64.00	06400	INTRAVENOUS THERAPY	0.098608	181	18	64.00
65.00	06500	RESPIRATORY THERAPY	0.365606	15,362	5,616	65.00
66.00	06600	PHYSICAL THERAPY	0.498199	35,996	17,933	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368803	31,189	11,503	67.00
68.00	06800	SPEECH PATHOLOGY	0.672368	3,997	2,687	68.00
69.00	06900	ELECTROCARDIOLOGY	0.146741	149	22	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.588257	1,924	1,132	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.840473	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.491530	30,318	14,902	73.00
76.00	03020	CARDIAC REHAB	2.188899	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	DCHMC	0.971839	0	0	88.00
88.01	08801	NDMC/ODON	1.192032	0	0	88.01
88.02	08802	QUICK CARE	0.875004	0	0	88.02
88.04	08803	PEDIATRICS	0.818317	0	0	88.04
88.05	08804	DAVIESS MARTIN	0.972254	0	0	88.05
90.00	09000	CLINIC	0.321181	0	0	90.00
91.00	09100	EMERGENCY	0.430257	40	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.162980	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.521687	0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		136,154	57,396	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)		136,154		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,819,296		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		982,589		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)		0		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)		38.08		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	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
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)		4.20		30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.36		31.00
32.00	Sum of lines 30 and 31		29.56		32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00		33.00
34.00	Disproportionate share adjustment (see instructions)		114,057		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/21/2015 12:29 pm

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000040791	0.000048650	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		369,009	372,057	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		275,998	93,779	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		369,777		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		4,285,719		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		4,285,719		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		299,268		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		4,584,987		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,584,987		61.00
62.00	Deductibles billed to program beneficiaries		624,896		62.00
63.00	Coinsurance billed to program beneficiaries		9,120		63.00
64.00	Allowable bad debts (see instructions)		142,887		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		92,877		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,536		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,043,848		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-18,385		70.93
70.94	HRR adjustment amount (see instructions)		-9,701		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150061	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/21/2015 12:29 pm
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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
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)	2014	363,269		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2015	118,526		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,497,557		71.00
71.01	Sequestration adjustment (see instructions)		89,951		71.01
72.00	Interim payments		4,424,152		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)		-16,546		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		11,406		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	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/21/2015 12:29 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2,819,296	0	2,819,296	0	2,819,296	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	982,589	0	0	982,589	982,589	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	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	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	114,057	0	84,579	29,478	114,057	11.00
11.01	Uncompensated care payments	36.00	369,777	0	275,998	93,779	369,777	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	4,285,719	0	3,179,873	1,105,846	4,285,719	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	4,285,719	0	3,179,873	1,105,846	4,285,719	15.00
16.00	Payment for inpatient program capital	50.00	299,268	0	221,969	77,299	299,268	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	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/21/2015 12:29 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,401,842	1,183,145	4,584,987	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	299,268	0	221,969	77,299	299,268	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	0	0	0	0	0	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	299,268	0	221,969	77,299	299,268	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				0.106786	0.100179		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			363,269		363,269	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				118,526	118,526	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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/21/2015 12:29 pm

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		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	2,819,296	2,819,296		2,819,296	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	982,589		982,589	982,589	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	0	0	0	0	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	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	114,057	84,579	29,478	114,057	11.00
11.01	Uncompensated care payments	36.00	369,777	275,998	93,779	369,777	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	4,285,719	3,179,873	1,105,846	4,285,719	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	4,285,719	3,179,873	1,105,846	4,285,719	15.00
16.00	Payment for inpatient program capital	50.00	299,268	221,969	77,299	299,268	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Capital 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			3,401,842	1,183,145	4,584,987	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/21/2015 12:29 pm

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		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	299,268	221,969	77,299	299,268	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	0	0	0	0	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	299,268	221,969	77,299	299,268	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	363,269	363,269		363,269	28.00
29.00	Low volume adjustment on or after October 1	70.97	118,526		118,526	118,526	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-18,385	-17,315	-1,070	-18,385	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	-9,701	-7,048	-2,653	-9,701	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.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150061	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	391	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,929,558	2.00
3.00	PPS payments	4,203,707	3.00
4.00	Outlier payment (see instructions)	10,954	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.824	5.00
6.00	Line 2 times line 5	4,061,956	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)	391	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	795	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	795	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)	795	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	404	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)	391	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)	4,214,661	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)	938,596	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} (for CAH, see instructions)	3,276,456	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,276,456	30.00
31.00	Primary payer payments	1,025	31.00
32.00	Subtotal (line 30 minus line 31)	3,275,431	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)	228,503	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	148,527	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	88,980	36.00
37.00	Subtotal (see instructions)	3,423,958	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-21	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,423,979	40.00
40.01	Sequestration adjustment (see instructions)	68,480	40.01
41.00	Interim payments	3,209,693	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	145,806	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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,389,252		3,209,693	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	07/30/2014	34,900		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)		34,900		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,424,152		3,209,693	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		145,806	6.01
6.02	SETTLEMENT TO PROGRAM		16,546		0	6.02
7.00	Total Medicare program liability (see instructions)		4,407,606		3,355,499	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150061 | Component CCN: 15S061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,323,878		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,323,878		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		26,328		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,350,206		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150061 | Component CCN: 15T061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,759,354		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,759,354		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,012		0	6.02
7.00	Total Medicare program liability (see instructions)		2,753,342		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150061 | Component CCN: 15U061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Swing Beds - SNF | PPS

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150061	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,561	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,285	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	208	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,570	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	105,866,636	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,213,410	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)	574,534	8.00
9.00	Sequestration adjustment amount (see instructions)	11,491	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	563,043	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	626,719	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-63,676	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 150061 Component CCN: 15U061	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Swing Beds - SNF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150061 Component CCN: 15S061	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	4,676,455	1.00
2.00	Net IPF PPS Outlier Payments	37,252	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	16.093151	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	4,713,707	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	4,713,707	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	4,713,707	18.00
19.00	Deductibles	234,400	19.00
20.00	Subtotal (line 18 minus line 19)	4,479,307	20.00
21.00	Coinsurance	67,184	21.00
22.00	Subtotal (line 20 minus line 21)	4,412,123	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	41,328	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	26,863	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	25,182	25.00
26.00	Subtotal (sum of lines 22 and 24)	4,438,986	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	4,438,986	31.00
31.01	Sequestration adjustment (see instructions)	88,780	31.01
32.00	Interim payments	4,323,878	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	26,328	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	37,252	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150061 Component CCN: 15T061	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2,838,079	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0147	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	34,057	3.00
4.00	Outlier Payments	4,998	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	6.956164	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2,877,134	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,877,134	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,877,134	19.00
20.00	Deductibles	48,608	20.00
21.00	Subtotal (line 19 minus line 20)	2,828,526	21.00
22.00	Coinsurance	22,528	22.00
23.00	Subtotal (line 21 minus line 22)	2,805,998	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	5,438	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	3,535	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,964	26.00
27.00	Subtotal (sum of lines 23 and 25)	2,809,533	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	2,809,533	32.00
32.01	Sequestration adjustment (see instructions)	56,191	32.01
33.00	Interim payments	2,759,354	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	-6,012	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	4,998	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/21/2015 12:29 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	993,896	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	16,044,412	0	0	0	4.00
5.00	Other receivable	2,614,117	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,013,004	0	0	0	6.00
7.00	Inventory	1,074,860	0	0	0	7.00
8.00	Prepaid expenses	683,644	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,397,925	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,280,955	0	0	0	12.00
13.00	Land improvements	687,865	0	0	0	13.00
14.00	Accumulated depreciation	-659,074	0	0	0	14.00
15.00	Buildings	60,354,021	0	0	0	15.00
16.00	Accumulated depreciation	-39,243,098	0	0	0	16.00
17.00	Leasehold improvements	39,119	0	0	0	17.00
18.00	Accumulated depreciation	-33,011	0	0	0	18.00
19.00	Fixed equipment	4,306,546	0	0	0	19.00
20.00	Accumulated depreciation	-3,100,042	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	26,823,551	0	0	0	23.00
24.00	Accumulated depreciation	-22,162,291	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	28,294,541	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,755,338	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	297,997	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,053,335	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,745,801	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,802,279	0	0	0	37.00
38.00	Salaries, wages, and fees payable	258,741	0	0	0	38.00
39.00	Payroll taxes payable	434,739	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,020,114	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	2,479,626	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,995,499	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	15,002,126	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	15,002,126	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	20,997,625	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,748,176				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)	23,748,176	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,745,801	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/21/2015 12:29 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		25,593,635		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,845,459				2.00
3.00	Total (sum of line 1 and line 2)		23,748,176		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)		23,748,176		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)		23,748,176		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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/21/2015 12:29 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	5,169,438		5,169,438	1.00
2.00	SUBPROVIDER - IPF	8,008,259		8,008,259	2.00
3.00	SUBPROVIDER - IRF	2,903,211		2,903,211	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)	16,080,908		16,080,908	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,634,741		2,634,741	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)	2,634,741		2,634,741	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,715,649		18,715,649	17.00
18.00	Ancillary services	22,369,596	58,550,227	80,919,823	18.00
19.00	Outpatient services	0	821,354	821,354	19.00
20.00	DCHMC	0	1,474,714	1,474,714	20.00
20.01	NDMC/ODON	0	1,326,840	1,326,840	20.01
20.02	QUICK CARE	0	1,465,431	1,465,431	20.02
20.04	PEDIATRICS	0	1,240,873	1,240,873	20.04
20.05	DAVIESS MARTIN	0	1,066,618	1,066,618	20.05
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		162,582	162,582	22.00
23.00	AMBULANCE SERVICES				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	0	846,110	846,110	26.00
27.00	OTHER REVENUE	0	5,504,569	5,504,569	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	41,085,245	72,459,318	113,544,563	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		56,358,806		29.00
30.00	IGT CONSULTING AND MISC EXPENSES	168,675			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)		168,675		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)		56,527,481		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/21/2015 12:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	113,544,563	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,069,625	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,474,938	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,527,481	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,052,543	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	7,416	6.00
7.00	Income from investments	34,952	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	4,009	10.00
11.00	Rebates and refunds of expenses	74,316	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	276,048	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	2,767	17.00
18.00	Revenue from sale of medical records and abstracts	25,475	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	163,862	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,618,239	24.00
25.00	Total other income (sum of lines 6-24)	2,207,084	25.00
26.00	Total (line 5 plus line 25)	-1,845,459	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,845,459	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H

HHA CCN: 157189 | Date/Time Prepared: 5/21/2015 12:29 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	94,359	0	0	0	34,421	128,780	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	49,054	0	5,698	0	0	54,752	6.00
7.00	Physical Therapy	17,612	0	3,094	0	0	20,706	7.00
8.00	Occupational Therapy	3,514	0	1,029	0	0	4,543	8.00
9.00	Speech Pathology	3,016	0	357	0	0	3,373	9.00
10.00	Medical Social Services	0	0	7	0	0	7	10.00
11.00	Home Health Aide	11,259	0	3,202	0	0	14,461	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	178,814	0	13,387	0	34,421	226,622	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	128,780	0	128,780			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	54,752	0	54,752			6.00
7.00	Physical Therapy	-20,706	0	0	0			7.00
8.00	Occupational Therapy	-4,543	0	0	0			8.00
9.00	Speech Pathology	-3,373	0	0	0			9.00
10.00	Medical Social Services	0	7	0	7			10.00
11.00	Home Health Aide	0	14,461	0	14,461			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-28,622	198,000	0	198,000			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: 150061 | HHA CCN: 157189 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

Home Health Agency I | PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	128,780	0	0	0	0	128,780	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	54,752	0	0	0	0	54,752	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	7	0	0	0	0	7	10.00
11.00	Home Health Aide	14,461	0	0	0	0	14,461	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	198,000	0	0	0	0	198,000	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	128,780		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	101,863	156,615	6.00
7.00	Physical Therapy	0	0	7.00
8.00	Occupational Therapy	0	0	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	13	20	10.00
11.00	Home Health Aide	26,904	41,365	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		198,000	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 150061 | HHA CCN: 157189 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part II | Date/Time Prepared: 5/21/2015 12:29 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	-128,780	69,220	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	54,752	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	7	10.00
11.00	Home Health Aide	0	0	0	0	0	14,461	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-128,780	69,220	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		128,780	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.860445	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150061 | HHA CCN: 157189 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	12,869	0	22,800	35,669	11,840	1.00
2.00	Skilled Nursing Care	156,615	0	0	11,853	168,468	55,919	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	20	0	0	0	20	7	6.00
7.00	Home Health Aide	41,365	0	0	2,720	44,085	14,633	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	198,000	12,869	0	37,373	248,242	82,399	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	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	11,880	17,647	0	8,139	0	2,976	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	1,333	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	922	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	11,880	17,647	0	8,139	0	5,231	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: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

HHA CCN: 157189 | Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	11,290	95	0	2,221	36,718	138,475	1.00
2.00	Skilled Nursing Care	5,056	0	0	0	0	230,776	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	27	6.00
7.00	Home Health Aide	3,495	0	0	0	0	63,135	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	19,841	95	0	2,221	36,718	432,413	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	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	138,475					1.00
2.00	Skilled Nursing Care	0	230,776	108,719	339,495			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	27	13	40			6.00
7.00	Home Health Aide	0	63,135	29,743	92,878			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	432,413	138,475	432,413			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.			0.471103				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: 150061 HHA CCN: 157189 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II Date/Time Prepared: 5/21/2015 12:29 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,365	0	94,359	0	35,669	1,365	1.00
2.00	Skilled Nursing Care	0	0	49,054	0	168,468	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	20	0	6.00
7.00	Home Health Aide	0	0	11,259	0	44,085	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,365	0	154,672		248,242	1,365	20.00
21.00	Total cost to be allocated	12,869	0	37,373		82,399	11,880	21.00
22.00	Unit cost multiplier	9.427839	0.000000	0.241627		0.331930	8.703297	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,365	0	1,365	0	3,934	3,934	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,762	1,762	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	1,218	1,218	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,365	0	1,365	0	6,914	6,914	20.00
21.00	Total cost to be allocated	17,647	0	8,139	0	5,231	19,841	21.00
22.00	Unit cost multiplier	12.928205	0.000000	5.962637	0.000000	0.756581	2.869685	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150061 HHA CCN: 157189

Period: From 01/01/2014 To 12/31/2014

Worksheet H-2 Part II Date/Time Prepared: 5/21/2015 12:29 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	373	0	162,582	1,962			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	373	0	162,582	1,962			20.00
21.00	Total cost to be allocated	95	0	2,221	36,718			21.00
22.00	Unit cost multiplier	0.254692	0.000000	0.013661	18.714577			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 150061 HHA CCN: 157189 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I Date/Time Prepared: 5/21/2015 12:29 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	339,495		339,495	901	376.80	1.00
2.00	Physical Therapy	3.00	0	23,264	23,264	481	48.37	2.00
3.00	Occupational Therapy	4.00	0	3,889	3,889	154	25.25	3.00
4.00	Speech Pathology	5.00	0	3,332	3,332	53	62.87	4.00
5.00	Medical Social Services	6.00	40		40	1	40.00	5.00
6.00	Home Health Aide	7.00	92,878		92,878	477	194.71	6.00
7.00	Total (sum of lines 1-6)		432,413	30,485	462,898	2,067		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	539			8.00
9.00	Physical Therapy		99915	0	345			9.00
10.00	Occupational Therapy		99915	0	77			10.00
11.00	Speech Pathology		99915	0	27			11.00
12.00	Medical Social Services		99915	0	1			12.00
13.00	Home Health Aide		99915	0	270			13.00
14.00	Total (sum of lines 8-13)			0	1,259			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	921	921	1,873	0.491725	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	539		0	203,095		1.00
2.00	Physical Therapy	0	345		0	16,688		2.00
3.00	Occupational Therapy	0	77		0	1,944		3.00
4.00	Speech Pathology	0	27		0	1,697		4.00
5.00	Medical Social Services	0	1		0	40		5.00
6.00	Home Health Aide	0	270		0	52,572		6.00
7.00	Total (sum of lines 1-6)	0	1,259		0	276,036		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/21/2015 12:29 pm

HHA CCN: 157189 | 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
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	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				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	203,095		1.00
2.00	Physical Therapy	16,688		2.00
3.00	Occupational Therapy	1,944		3.00
4.00	Speech Pathology	1,697		4.00
5.00	Medical Social Services	40		5.00
6.00	Home Health Aide	52,572		6.00
7.00	Total (sum of lines 1-6)	276,036		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II | Date/Time Prepared: 5/21/2015 12:29 pm

HHA CCN: 157189 | 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	0.498199	46,697	23,264	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.368803	10,544	3,889	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.672368	4,955	3,332	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.588257	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.491530	1,873	921	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 150061 | HHA CCN: 157189 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	160,838	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	3,269	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,121	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	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	166,228	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	166,228	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	166,228	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	166,228	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	166,228	31.00
31.01	Sequestration adjustment (see instructions)	0	3,324	31.01
32.00	Interim payments (see instructions)	0	162,904	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 150061 HHA CCN: 157189

Period: From 01/01/2014 To 12/31/2014

Worksheet H-5

Date/Time Prepared: 5/21/2015 12:29 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		162,904	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		162,904	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		162,904	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150061 Hospice CCN: 151553 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K | Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	22,274	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	118,132	0	0	0	63,490	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	64,180	0	0	156,344	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	36,737	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	219,049	0	22,274	156,344	63,490	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150061 Hospice CCN: 151553 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K | Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	22,274	0	22,274	0	22,274	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	181,622	0	181,622	0	181,622	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	220,524	0	220,524	0	220,524	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	36,737	0	36,737	0	36,737	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	461,157	0	461,157	0	461,157	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150061 Hospice CCN: 151553

Period: From 01/01/2014 To 12/31/2014

Worksheet K-1

Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	98,817	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	64,180	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	98,817	0	0	0	64,180	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES | Provider CCN: 150061 Hospice CCN: 151553 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-1 Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	19,315	118,132		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	64,180		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		36,737	0	36,737		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	36,737	19,315	219,049		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 150061 Hospice CCN: 151553 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-3 Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	156,344	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	156,344	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 150061 Hospice CCN: 151553

Period: From 01/01/2014 To 12/31/2014

Worksheet K-3

Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	156,344		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	156,344		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150061 Hospice CCN: 151553

Period: From 01/01/2014 To 12/31/2014

Worksheet K-4 Part I Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	22,274	0	0	0	22,274	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	181,622	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	220,524	0	0	0	22,274	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	36,737	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	461,157	0	0	0	22,274	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 150061 Hospice CCN: 151553 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part I Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	181,622	181,622			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	242,798	157,753	400,551		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	0	0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	36,737	23,869	60,606		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	461,157		461,157		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150061 Hospice CCN: 151553 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part II Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	22,274		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	22,274	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	22,274	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	1.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150061 Hospice CCN: 151553 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part II Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-181,622	279,535		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	242,798		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	36,737		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		181,622		39.00
40.00	Unit Cost Multiplier		0.649729		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150061
Hospice CCN: 151553

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part I
Date/Time Prepared:
5/21/2015 12:29 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		0	0	28,543	28,543	1.00
2.00	Inpatient - General Care	400,551	5,515	0	15,508	421,574	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	60,606	0	0	8,877	69,483	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	461,157	5,515	0	52,928	519,600	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150061
Hospice CCN: 151553

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part I
Date/Time Prepared:
5/21/2015 12:29 pm

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
1.00	Administrative and General	9,474	0	0	0	0	1.00
2.00	Inpatient - General Care	139,933	5,091	7,563	0	3,488	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	23,063	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	172,470	5,091	7,563	0	3,488	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150061
Hospice CCN: 151553

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part I
Date/Time Prepared:
5/21/2015 12:29 pm

Hospice I

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	7,683	29,142	14,529	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	7,683	29,142	14,529	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150061 Hospice CCN: 151553

Period: From 01/01/2014 To 12/31/2014

Worksheet K-5 Part I Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	
		16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	38,017			1.00
2.00	Inpatient - General Care	11,558	55,077	695,638	0	695,638	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	92,546	0	92,546	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	11,558	55,077	826,201	0	826,201	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150061 Hospice CCN: 151553

Period: From 01/01/2014 To 12/31/2014

Worksheet K-5 Part I Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

	Cost Center Description	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Inpatient - General Care	33,553	729,191		2.00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physician Services	0	0		4.00
5.00	Nursing Care	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech/ Language Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Spiritual Counseling	0	0		11.00
12.00	Dietary Counseling	0	0		12.00
13.00	Counseling - Other	0	0		13.00
14.00	Home Health Aide and Homemaker	4,464	97,010		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		15.00
16.00	Other	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		17.00
18.00	Analgesics	0	0		18.00
19.00	Sedatives / Hypnotics	0	0		19.00
20.00	Other - Specify	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0		21.00
22.00	Patient Transportation	0	0		22.00
23.00	Imaging Services	0	0		23.00
24.00	Labs and Diagnostics	0	0		24.00
25.00	Medical Supplies	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		26.00
27.00	Radiation Therapy	0	0		27.00
28.00	Chemotherapy	0	0		28.00
29.00	Other	0	0		29.00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31.00
32.00	Fundraising	0	0		32.00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)		826,201		34.00
35.00	Unit Cost Multiplier (see instructions)	0.048234			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150061
Hospice CCN: 151553

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part II
Date/Time Prepared:
5/21/2015 12:29 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	0	118,132	0	28,543	1.00
2.00	Inpatient - General Care	585	0	64,180	0	421,574	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	36,737	0	69,483	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	585	0	219,049		519,600	34.00
35.00	Total cost to be allocated	5,515	0	52,928		172,470	35.00
36.00	Unit Cost Multiplier (see instructions)	9.427350	0.000000	0.241626		0.331928	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150061
Hospice CCN: 151553

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part II
Date/Time Prepared:
5/21/2015 12:29 pm

Hospice I

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	585	585	0	585	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	585	585	0	585	0	34.00
35.00	Total cost to be allocated	5,091	7,563	0	3,488	0	35.00
36.00	Unit Cost Multiplier (see instructions)	8.702564	12.928205	0.000000	5.962393	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150061
Hospice CCN: 151553

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part II
Date/Time Prepared:
5/21/2015 12:29 pm

Hospice I

	Cost Center Description	CAFETERIA (HOURS PAID)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	10,155	10,155	57,296	0	846,110	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	10,155	10,155	57,296	0	846,110	34.00
35.00	Total cost to be allocated	7,683	29,142	14,529	0	11,558	35.00
36.00	Unit Cost Multiplier (see instructions)	0.756573	2.869719	0.253578	0.000000	0.013660	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150061
Hospice CCN: 151553

Period:
From 01/01/2014
To 12/31/2014

Worksheet K-5
Part II
Date/Time Prepared:
5/21/2015 12:29 pm

Hospice I

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
		17.00		
1.00	Administrative and General	0		1.00
2.00	Inpatient - General Care	2,943		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	0		4.00
5.00	Nursing Care	0		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,943		34.00
35.00	Total cost to be allocated	55,077		35.00
36.00	Unit Cost Multiplier (see instructions)	18.714577		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150061 Hospice CCN: 151553

Period: From 01/01/2014 To 12/31/2014

Worksheet K-5 Part III Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.498199	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.368803	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.672368	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.491530	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.185914	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.588257	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.521687	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	CARDIAC REHAB	76.00	2.188899	0	0	10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150061 Hospice CCN: 151553

Period: From 01/01/2014 To 12/31/2014

Worksheet K-6

Date/Time Prepared: 5/21/2015 12:29 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				826,201	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,380	2.00
3.00	Average cost per diem (line 1 divided by line 2)				244.44	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	2,946				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	720,120				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			434		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			106,087		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150061	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	299,268	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	13.21	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	299,268	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 Component CCN: 158500 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	21,418	0	21,418	0	21,418	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	197,078	0	197,078	0	197,078	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	131,457	0	131,457	0	131,457	9.00
10.00	Subtotal (sum of lines 1 through 9)	349,953	0	349,953	0	349,953	10.00
11.00	Physician Services Under Agreement	0	265,700	265,700	0	265,700	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	265,700	265,700	0	265,700	14.00
15.00	Medical Supplies	0	31,796	31,796	0	31,796	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,796	31,796	0	31,796	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	349,953	297,496	647,449	0	647,449	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	68,115	68,115	0	68,115	29.00
30.00	Administrative Costs	82,376	0	82,376	0	82,376	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	82,376	68,115	150,491	0	150,491	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	432,329	365,611	797,940	0	797,940	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 | Component CCN: 158500 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	21,418		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	197,078		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	131,457		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	349,953		10.00
11.00	Physician Services Under Agreement	0	265,700		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	265,700		14.00
15.00	Medical Supplies	0	31,796		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,796		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	647,449		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	68,115		29.00
30.00	Administrative Costs	0	82,376		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	150,491		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	797,940		32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 Component CCN: 153999 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	422,609	0	422,609	0	422,609	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	76,149	0	76,149	0	76,149	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	182,082	0	182,082	0	182,082	9.00
10.00	Subtotal (sum of lines 1 through 9)	680,840	0	680,840	0	680,840	10.00
11.00	Physician Services Under Agreement	0	51,477	51,477	0	51,477	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	51,477	51,477	0	51,477	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	680,840	51,477	732,317	0	732,317	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	64,788	64,788	0	64,788	29.00
30.00	Administrative Costs	67,121	0	67,121	0	67,121	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	67,121	64,788	131,909	0	131,909	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	747,961	116,265	864,226	0	864,226	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 | Component CCN: 153999 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	422,609		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	76,149		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	182,082		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	680,840		10.00
11.00	Physician Services Under Agreement	0	51,477		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	51,477		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	732,317		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	64,788		29.00
30.00	Administrative Costs	0	67,121		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	131,909		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	864,226		32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 Component CCN: 158501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	6,000	0	6,000	0	6,000	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	275,408	0	275,408	0	275,408	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	199,840	0	199,840	0	199,840	9.00
10.00	Subtotal (sum of lines 1 through 9)	481,248	0	481,248	0	481,248	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	21,417	21,417	0	21,417	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21,417	21,417	0	21,417	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	481,248	21,417	502,665	0	502,665	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	100,247	100,247	0	100,247	29.00
30.00	Administrative Costs	43,686	0	43,686	0	43,686	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,686	100,247	143,933	0	143,933	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	524,934	121,664	646,598	0	646,598	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 | Component CCN: 158501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	6,000		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	275,408		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	199,840		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	481,248		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	21,417		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	21,417		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	502,665		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	100,247		29.00
30.00	Administrative Costs	0	43,686		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	143,933		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	646,598		32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 Component CCN: 158503 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) V | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	220,622	0	220,622	0	220,622	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	94,923	0	94,923	0	94,923	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	97,519	0	97,519	0	97,519	9.00
10.00	Subtotal (sum of lines 1 through 9)	413,064	0	413,064	0	413,064	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	92,093	92,093	0	92,093	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	92,093	92,093	0	92,093	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	413,064	92,093	505,157	0	505,157	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	31,395	31,395	0	31,395	29.00
30.00	Administrative Costs	37,088	0	37,088	0	37,088	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	37,088	31,395	68,483	0	68,483	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	450,152	123,488	573,640	0	573,640	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 Component CCN: 158503 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) V | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	220,622		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	94,923		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	97,519		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	413,064		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	92,093		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	92,093		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	505,157		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	31,395		29.00
30.00	Administrative Costs	0	37,088		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	68,483		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	573,640		32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 Component CCN: 158506 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) VI | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	134,500	0	134,500	0	134,500	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	146,522	0	146,522	0	146,522	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	133,554	0	133,554	0	133,554	9.00
10.00	Subtotal (sum of lines 1 through 9)	414,576	0	414,576	0	414,576	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	36,655	36,655	0	36,655	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	36,655	36,655	0	36,655	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	414,576	36,655	451,231	0	451,231	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	54,432	54,432	0	54,432	29.00
30.00	Administrative Costs	43,046	0	43,046	0	43,046	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	43,046	54,432	97,478	0	97,478	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	457,622	91,087	548,709	0	548,709	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 150061 | Component CCN: 158506 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) VI | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	134,500		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	146,522		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	133,554		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	414,576		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	36,655		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	36,655		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	451,231		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	54,432		29.00
30.00	Administrative Costs	0	43,046		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	97,478		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	548,709		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150061 | Component CCN: 158500 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.97	4,039	4,200	4,074		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.97	7,949	2,100	4,137		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.94	11,988		8,211	11,988	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.94	11,988			11,988	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					647,449	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					647,449	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					150,491	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					635,245	15.00
16.00	Total overhead (sum of lines 14 and 15)					785,736	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					785,736	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					785,736	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,433,185	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150061 | Component CCN: 153999 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.05	8,332	4,200	8,610		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.94	2,652	2,100	1,974		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.99	10,984		10,584	10,984	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.99	10,984			10,984	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					732,317	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					732,317	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					131,909	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					717,410	15.00
16.00	Total overhead (sum of lines 14 and 15)					849,319	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					849,319	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					849,319	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,581,636	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150061 Component CCN: 158501

Period: From 01/01/2014 To 12/31/2014

Worksheet M-2

Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) III

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.96	8,411	2,100	6,216		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.96	8,411		6,216	8,411	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.96	8,411			8,411	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					502,665	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					502,665	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					143,933	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					635,660	15.00
16.00	Total overhead (sum of lines 14 and 15)					779,593	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					779,593	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					779,593	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,282,258	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150061 | Component CCN: 158503 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) V | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.93	5,756	4,200	3,906		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.96	4,163	2,100	2,016		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.89	9,919		5,922	9,919	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.89	9,919			9,919	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					505,157	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					505,157	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					68,483	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					441,787	15.00
16.00	Total overhead (sum of lines 14 and 15)					510,270	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					510,270	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					510,270	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,015,427	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150061 | Component CCN: 158506 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) VI | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.75	1,734	4,200	3,150		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.75	6,222	2,100	3,675		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.50	7,956		6,825	7,956	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.50	7,956			7,956	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					451,231	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					451,231	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					97,478	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					488,315	15.00
16.00	Total overhead (sum of lines 14 and 15)					585,793	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					585,793	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					585,793	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,037,024	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 150061 Component CCN: 158500 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Rural Health Clinic (RHC) I | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,433,185	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		30,685	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,402,500	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		11,988	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		11,988	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		116.99	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	116.99	116.99	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,463	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	405,136	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		405,136	16.00
16.01	Total program charges (see instructions)(from contractor's records)		575,371	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		251	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		177	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		290,753	16.04
16.05	Total program cost (see instructions)		290,930	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		41,518	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		106,727	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		290,930	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,844	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		304,774	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		304,774	26.00
26.01	Sequestration adjustment (see instructions)		6,095	26.01
27.00	Interim payments		311,186	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		-12,507	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 150061 | Component CCN: 153999 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Rural Health Clinic (RHC) II | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,581,636	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		57,769	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,523,867	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		10,984	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		10,984	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		138.74	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	138.74	138.74	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,811	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	389,998	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		389,998	16.00
16.01	Total program charges (see instructions)(from contractor's records)		462,755	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,037	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,717	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		280,499	16.04
16.05	Total program cost (see instructions)		282,216	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		37,657	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		84,616	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		282,216	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		19,953	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		302,169	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		302,169	26.00
26.01	Sequestration adjustment (see instructions)		6,043	26.01
27.00	Interim payments		239,506	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		56,620	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 150061 Component CCN: 158501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Rural Health Clinic (RHC) III | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,282,258	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,282,258	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		8,411	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		8,411	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		152.45	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	152.45	152.45	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	788	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	120,131	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		120,131	16.00
16.01	Total program charges (see instructions)(from contractor's records)		151,266	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		85,253	16.04
16.05	Total program cost (see instructions)		85,253	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,565	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		27,541	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		85,253	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		85,253	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		85,253	26.00
26.01	Sequestration adjustment (see instructions)		1,705	26.01
27.00	Interim payments		66,770	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		16,778	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 150061 | Component CCN: 158503 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Rural Health Clinic (RHC) V | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,015,427	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,015,427	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		9,919	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		9,919	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		102.37	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	102.37	102.37	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)		0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 150061 | Component CCN: 158506 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Rural Health Clinic (RHC) VI | Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,037,024	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		35,972	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,001,052	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		7,956	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,956	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		125.82	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	125.82	125.82	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,522	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	317,318	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		317,318	16.00
16.01	Total program charges (see instructions)(from contractor's records)		404,594	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,348	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,979	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		224,931	16.04
16.05	Total program cost (see instructions)		229,910	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		31,175	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		73,419	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		229,910	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		20,993	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		250,903	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		250,903	26.00
26.01	Sequestration adjustment (see instructions)		5,018	26.01
27.00	Interim payments		203,537	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		42,348	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 150061 Component CCN: 158500	Period: From 01/01/2014 To 12/31/2014	Worksheet M-4 Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	349,953	349,953	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000112	0.002300	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	39	805	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,171	8,847	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,210	9,652	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	647,449	647,449	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	785,736	785,736	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006502	0.014908	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,109	11,714	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,319	21,366	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	61	317	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	152.77	67.40	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	9	185	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,375	12,469	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		30,685	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		13,844	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 150061 | Component CCN: 153999 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-4 | Date/Time Prepared: 5/21/2015 12:29 pm

Title XVIII | Rural Health Clinic (RHC) II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	680,840	680,840	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000206	0.002755	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	140	1,876	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	8,684	16,048	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	8,824	17,924	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	732,317	732,317	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	849,319	849,319	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.012049	0.024476	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,233	20,788	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	19,057	38,712	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	127	575	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	150.06	67.33	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	19	254	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,851	17,102	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		57,769	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		19,953	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 150061 Component CCN: 158506	Period: From 01/01/2014 To 12/31/2014	Worksheet M-4 Date/Time Prepared: 5/21/2015 12:29 pm
	Title XVIII	Rural Health Clinic (RHC) VI	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	414,576	414,576	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000467	0.002925	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	194	1,213	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,923	9,322	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,117	10,535	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	451,231	451,231	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	585,793	585,793	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011340	0.023347	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,643	13,677	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	11,760	24,212	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	72	334	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	163.33	72.49	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	34	213	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,553	15,440	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		35,972	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		20,993	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150061 Component CCN: 158500 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		311,186	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		311,186	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		12,507	6.02
7.00	Total Medicare program liability (see instructions)		298,679	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150061 Component CCN: 153999 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		239,506	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		239,506	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		56,620	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		296,126	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150061 | Component CCN: 158501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		66,770	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		66,770	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		16,778	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		83,548	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150061 Component CCN: 158506 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 5/21/2015 12:29 pm

Rural Health Clinic (RHC) VI | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		203,537	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		203,537	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		42,348	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		245,885	7.00

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