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: 140120	Period: From 05/01/2014 To 04/30/2015	Worksheet S Parts I-III Date/Time Prepared: 9/28/2015 2:30 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/28/2015 Time: 2:30 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 PEKIN MEMORIAL HOSPITAL (140120) for the cost reporting period beginning 05/01/2014 and ending 04/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	21,267	-57,914	9,242	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	96		0	9.00
200.00	Total	0	21,267	-57,818	9,242	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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 SOUTH 13TH STREET	PO Box:			1.00
2.00	City: PEKIN	State: IL	Zip Code: 61554	County: TAZWELL	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	PEKIN MEMORIAL HOSPITAL	140120	37900	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PEKIN HOME HEALTH	147057	37900		01/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2014	04/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,576	915	0	0	160	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/28/2015 2:27 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		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.	1		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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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	Y	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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/28/2015 2:27 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/28/2015 2:27 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
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	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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	471,911	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	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

		1.00	2.00	
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)	Y	14H076	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: PROGRESSIVE HEALTH SYSTEMS	Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC	Contractor's Number: 00131	141.00
142.00	Street: 600 SOUTH 13TH STREET	PO Box:		142.00
143.00	City: PEKIN	State: IL	Zip Code: 61554	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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140120	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/28/2015 2:27 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/28/2015 2:27 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.	Y	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	08/13/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/28/2015 2:27 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		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.	Y		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.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		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.	KEVIN	WELLEN	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.	(314) 231-5544	STLHEALTHCARE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/28/2015 2:27 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)	08/13/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/28/2015 2:27 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	99	36,135	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)		99	36,135	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		107	39,055	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	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						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		107				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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 9/28/2015 2:27 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)	6,845	1,005	13,195			1.00
2.00	HMO and other (see instructions)	2,446	1,124				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,845	1,005	13,195			7.00
8.00	INTENSIVE CARE UNIT	616	0	1,215			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		441	884			13.00
14.00	Total (see instructions)	7,461	1,446	15,294	0.00	514.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	4,402	0	7,140	0.00	5.84	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	520.57	27.00
28.00	Observation Bed Days		549	2,175			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			76			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	81	111			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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/28/2015 2:27 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	1,547	599	3,527	1.00
2.00	HMO and other (see instructions)			507	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	1,547	599	3,527	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 9/28/2015 2:27 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	26,532,759	0	26,532,759	1,082,792.92	24.50	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		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		2,655,404	0	2,655,404	55,588.00	47.77	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		380,734	90	380,824	13,884.80	27.43	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,379,080	0	1,379,080	29,674.95	46.47	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		12,000	0	12,000	120.00	100.00	13.00
14.00	Home office salaries & wage-related costs		2,149,777	0	2,149,777	45,468.91	47.28	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,883,546	0	5,883,546			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		81,196	0	81,196			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		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-73,871	236,374	162,503	9,572.00	16.98	26.00
27.00	Administrative & General	5.00	5,852,436	-236,374	5,616,062	211,128.49	26.60	27.00
28.00	Administrative & General under contract (see inst.)		692,050	0	692,050	2,199.50	314.64	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	503,190	0	503,190	21,409.27	23.50	30.00
31.00	Laundry & Linen Service	8.00	167,945	0	167,945	12,664.09	13.26	31.00
32.00	Housekeeping	9.00	664,870	0	664,870	59,692.76	11.14	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	719,074	-571,984	147,090	11,122.74	13.22	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	571,984	571,984	43,240.58	13.23	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	879,127	0	879,127	26,647.18	32.99	38.00
39.00	Central Services and Supply	14.00	114,720	0	114,720	7,315.65	15.68	39.00
40.00	Pharmacy	15.00	803,197	-803,197	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 9/28/2015 2:27 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	638,092	0	638,092	34,670.00	18.40	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 9/28/2015 2:27 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)		24,569,405	0	24,569,405	1,029,404.42	23.87	1.00
2.00	Excluded area salaries (see instructions)		380,734	90	380,824	13,884.80	27.43	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,188,671	-90	24,188,581	1,015,519.62	23.82	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,540,857	0	3,540,857	75,263.86	47.05	4.00
5.00	Subtotal wage-related costs (see inst.)		5,883,546	0	5,883,546	0.00	24.32	5.00
6.00	Total (sum of lines 3 thru 5)		33,613,074	-90	33,612,984	1,090,783.48	30.82	6.00
7.00	Total overhead cost (see instructions)		10,960,830	-803,197	10,157,633	439,662.26	23.10	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 9/28/2015 2:27 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	664,100	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	224,370	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	26,350	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)	2,622,158	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)	33,179	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	380,087	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,912,391	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	80,440	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	21,667	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,964,742	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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 9/28/2015 2:27 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	2,362,346	85,009	1.00
2.00	Hospital	2,071,129	85,009	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	291,217	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140120 | Component CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-4 | Date/Time Prepared: 9/28/2015 2:27 pm

Home Health Agency I | PPS

					1.00		
0.00	County				TAZWELL		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	311	0	0	311	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	378.00	20.00	69.00	467.00	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)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			1.00	0.00	1.00	5.00
6.00	Direct Nursing Service			2.69	0.00	2.69	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.15	0.00	0.15	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			37900			20.00
20.01				99914			20.01
		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	1,541	21	93	69	1,724	21.00
22.00	Skilled Nursing Visit Charges	231,074	3,306	11,310	10,092	255,782	22.00
23.00	Physical Therapy Visits	1,850	32	45	50	1,977	23.00
24.00	Physical Therapy Visit Charges	335,920	6,080	3,990	9,500	355,490	24.00
25.00	Occupational Therapy Visits	400	31	1	6	438	25.00
26.00	Occupational Therapy Visit Charges	73,536	5,952	192	1,152	80,832	26.00
27.00	Speech Pathology Visits	63	27	0	2	92	27.00
28.00	Speech Pathology Visit Charges	13,041	5,589	0	414	19,044	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	162	0	6	3	171	31.00
32.00	Home Health Aide Visit Charges	12,561	0	79	237	12,877	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,016	111	145	130	4,402	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)	666,132	20,927	15,571	21,395	724,025	35.00
36.00	Total Number of Episodes (standard/non outlier)	240		31	10	281	36.00
37.00	Total Number of Outlier Episodes		2		1	3	37.00
38.00	Total Non-Routine Medical Supply Charges	5,411	0	233	18	5,662	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-10 | Date/Time Prepared: 9/28/2015 2:27 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)	0.206799	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,106,278	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?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,553,616	5.00
6.00	Medicaid charges	50,382,846	6.00
7.00	Medicaid cost (line 1 times line 6)	10,419,122	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)	2,759,228	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	35,556	9.00
10.00	Stand-alone SCHIP charges	330,921	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	68,434	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	32,878	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)	2,792,106	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	495,355	166,493	661,848	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	102,439	34,431	136,870	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)	102,439	34,431	136,870	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,149,425	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	257,370	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,892,055	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,011,672	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,148,542	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,940,648	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,592,820	1,592,820	652,325	2,245,145	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,317,877	2,317,877	42,276	2,360,153	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-73,871	5,822,535	5,748,664	476,508	6,225,172	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,852,436	9,905,528	15,757,964	-1,113,601	14,644,363	5.00
7.00	00700	OPERATION OF PLANT	503,190	1,532,279	2,035,469	15,702	2,051,171	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	167,945	82,406	250,351	0	250,351	8.00
9.00	00900	HOUSEKEEPING	664,870	405,087	1,069,957	0	1,069,957	9.00
10.00	01000	DIETARY	719,074	888,963	1,608,037	-1,279,106	328,931	10.00
11.00	01100	CAFETERIA	0	0	0	1,279,106	1,279,106	11.00
13.00	01300	NURSING ADMINISTRATION	879,127	173,408	1,052,535	-99	1,052,436	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,720	247,154	361,874	-267,072	94,802	14.00
15.00	01500	PHARMACY	803,197	2,285,353	3,088,550	-2,792,543	296,007	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	638,092	457,417	1,095,509	0	1,095,509	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,098,112	562,121	6,660,233	-1,157,584	5,502,649	30.00
31.00	03100	INTENSIVE CARE UNIT	1,161,643	40,120	1,201,763	23,648	1,225,411	31.00
43.00	04300	NURSERY	0	0	0	237,659	237,659	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,290,411	4,075,588	6,365,999	-3,626,244	2,739,755	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	713,114	713,114	52.00
53.00	05300	ANESTHESIOLOGY	0	1,263,987	1,263,987	-183,053	1,080,934	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,241,213	347,259	1,588,472	102,756	1,691,228	54.00
56.00	05600	RADIOISOTOPE	139,528	281,144	420,672	-1,926	418,746	56.00
57.00	05700	CT SCAN	184,235	215,946	400,181	34,738	434,919	57.00
58.00	05800	MRI	145,429	60,185	205,614	-21,822	183,792	58.00
59.00	05900	CARDIAC CATHETERIZATION	210,432	286,153	496,585	-217,541	279,044	59.00
60.00	06000	LABORATORY	1,124,857	1,396,898	2,521,755	-54,375	2,467,380	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	563,205	563,205	41,813	605,018	63.00
65.00	06500	RESPIRATORY THERAPY	400,751	94,458	495,209	-59,795	435,414	65.00
66.00	06600	PHYSICAL THERAPY	0	684,236	684,236	-1,150	683,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	64,031	64,031	-23	64,008	67.00
68.00	06800	SPEECH PATHOLOGY	0	127,467	127,467	127	127,594	68.00
69.00	06900	ELECTROCARDIOLOGY	396,275	335,226	731,501	2,842	734,343	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,359,666	3,359,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,898,219	1,898,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,809,892	2,809,892	73.00
76.00	03610	SLEEP LAB	0	119,619	119,619	-17	119,602	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	314,342	235,129	549,471	-46,721	502,750	90.00
91.00	09100	EMERGENCY	2,176,017	386,786	2,562,803	-279,196	2,283,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	362,406	380,681	743,087	-5,177	737,910	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		583,346	583,346	-583,346	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,514,431	37,814,412	64,328,843	0	64,328,843	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,328	1,655	19,983	0	19,983	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	26,532,759	37,816,067	64,348,826	0	64,348,826	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,135	2,244,010		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-192,778	2,167,375		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-959,529	5,265,643		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,222,152	9,422,211		5.00
7.00	00700	OPERATION OF PLANT	0	2,051,171		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	250,351		8.00
9.00	00900	HOUSEKEEPING	-65,884	1,004,073		9.00
10.00	01000	DIETARY	-60	328,871		10.00
11.00	01100	CAFETERIA	-558,519	720,587		11.00
13.00	01300	NURSING ADMINISTRATION	-123,157	929,279		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	94,802		14.00
15.00	01500	PHARMACY	-825	295,182		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-43,416	1,052,093		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-8,791	5,493,858		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,225,411		31.00
43.00	04300	NURSERY	-887	236,772		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-33	2,739,722		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	713,114		52.00
53.00	05300	ANESTHESIOLOGY	-1,080,934	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-10,337	1,680,891		54.00
56.00	05600	RADIOISOTOPE	0	418,746		56.00
57.00	05700	CT SCAN	-180	434,739		57.00
58.00	05800	MRI	0	183,792		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	279,044		59.00
60.00	06000	LABORATORY	-67,500	2,399,880		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	605,018		63.00
65.00	06500	RESPIRATORY THERAPY	0	435,414		65.00
66.00	06600	PHYSICAL THERAPY	-8,287	674,799		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	64,008		67.00
68.00	06800	SPEECH PATHOLOGY	0	127,594		68.00
69.00	06900	ELECTROCARDIOLOGY	-289,258	445,085		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-478	3,359,188		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,898,219		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,809,892		73.00
76.00	03610	SLEEP LAB	-119,250	352		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-13,602	489,148		90.00
91.00	09100	EMERGENCY	0	2,283,607		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-1,493	736,417		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,768,485	55,560,358		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,983		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	LEASED SPACE	0	0		194.01
194.02	07952	FOUNDATION	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,768,485	55,580,341		200.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/28/2015 2:27 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	571,984	707,122		1.00
	0		571,984	707,122		
	B - TO RECLASS BLOOD SALARIES FROM LAB					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	42,970	0		1.00
	0		42,970	0		
	C - TO RECLASS LDR EXPENSES					
1.00	NURSERY	43.00	228,669	6,530		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	686,143	19,593		2.00
	0		914,812	26,123		
	D - TO RECLASS CLINICAL ENGINEERING EXPE					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,580		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	10,374		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	24,974		3.00
4.00	NURSERY	43.00	0	2,390		4.00
5.00	OPERATING ROOM	50.00	0	108,361		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,169		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	148,733		7.00
8.00	RADIOISOTOPE	56.00	0	1,813		8.00
9.00	CT SCAN	57.00	0	73,344		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	55,983		10.00
11.00	LABORATORY	60.00	0	28,817		11.00
12.00	RESPIRATORY THERAPY	65.00	0	15,856		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,791		13.00
14.00	SPEECH PATHOLOGY	68.00	0	127		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	6,699		15.00
16.00	CLINIC	90.00	0	5,496		16.00
17.00	EMERGENCY	91.00	0	12,152		17.00
18.00	HOME HEALTH AGENCY	101.00	0	53		18.00
	0		0	523,712		
	E - TO RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,359,666		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,898,219		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	0		0	5,257,885		
	F - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,032,426		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	0		0	2,032,426		
	G - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,809		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	2,809		

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	H - TO RECLASS HUMAN RESOURCES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	236,374	240,134		1.00
	0		236,374	240,134		
	I - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	583,346		1.00
	0		0	583,346		
	J - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	111,255		1.00
	0		0	111,255		
	K - TO RECLASS MRI LEASE EXPENSE					
1.00	MRI	58.00	0	4,935		1.00
	0		0	4,935		
	L - TO RECLASS MRI BLDG UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	15,702		1.00
	0		0	15,702		
	M - TO RECLASS PHARMACY SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	676	0		1.00
2.00	NURSERY	43.00	70	0		2.00
3.00	OPERATING ROOM	50.00	10,719	0		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	209	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	3,171	0		5.00
6.00	RADIOISOTOPE	56.00	104	0		6.00
7.00	MRI	58.00	4,095	0		7.00
8.00	LABORATORY	60.00	41	0		8.00
9.00	RESPIRATORY THERAPY	65.00	33	0		9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	777,466	0		10.00
11.00	CLINIC	90.00	6,375	0		11.00
12.00	EMERGENCY	91.00	148	0		12.00
13.00	HOME HEALTH AGENCY	101.00	90	0		13.00
	0		803,197	0		
	N - TO RECLASS ANESTHESIOLOGY EXPENSE					
1.00	OPERATING ROOM	50.00	0	183,053		1.00
	TOTALS		0	183,053		
500.00	Grand Total: Increases		2,569,337	9,688,502		500.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/28/2015 2:27 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - TO RECLASS CAFETERIA COSTS					
1.00	DIETARY	10.00	571,984	707,122	0	1.00
	0		571,984	707,122		
	B - TO RECLASS BLOOD SALARIES FROM LAB					
1.00	LABORATORY	60.00	42,970	0	0	1.00
	0		42,970	0		
	C - TO RECLASS LDR EXPENSES					
1.00	ADULTS & PEDIATRICS	30.00	914,812	26,123	0	1.00
2.00		0.00	0	0	0	2.00
	0		914,812	26,123		
	D - TO RECLASS CLINICAL ENGINEERING EXPE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	523,712	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
	0		0	523,712		
	E - TO RECLASS SUPPLY COSTS					
1.00	NURSING ADMINISTRATION	13.00	0	99	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	265,018	0	2.00
3.00	PHARMACY	15.00	0	9,510	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	227,510	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	1,326	0	5.00
6.00	OPERATING ROOM	50.00	0	3,918,859	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	47,728	0	7.00
8.00	RADIOISOTOPE	56.00	0	3,843	0	8.00
9.00	CT SCAN	57.00	0	38,458	0	9.00
10.00	MRI	58.00	0	2,524	0	10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	273,524	0	11.00
12.00	LABORATORY	60.00	0	40,263	0	12.00
13.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,157	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	75,684	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	2,941	0	15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	23	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	3,857	0	17.00
18.00	SLEEP LAB	76.00	0	17	0	18.00
19.00	CLINIC	90.00	0	58,585	0	19.00
20.00	EMERGENCY	91.00	0	282,210	0	20.00
21.00	HOME HEALTH AGENCY	101.00	0	4,749	0	21.00
	0		0	5,257,885		
	F - TO RECLASS BILLABLE DRUGS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	21,634	0	1.00
2.00	PHARMACY	15.00	0	1,979,836	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	189	0	3.00
4.00	OPERATING ROOM	50.00	0	9,518	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	341	0	5.00
6.00	CT SCAN	57.00	0	148	0	6.00
7.00	MRI	58.00	0	11,467	0	7.00
8.00	CLINIC	90.00	0	7	0	8.00
9.00	EMERGENCY	91.00	0	9,286	0	9.00
	0		0	2,032,426		
	G - TO RECLASS TELEPHONE EXPENSE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,079	0	1.00
2.00	MRI	58.00	0	1,159	0	2.00
3.00	HOME HEALTH AGENCY	101.00	0	571	0	3.00
	0		0	2,809		
	H - TO RECLASS HUMAN RESOURCES					
1.00	ADMINISTRATIVE & GENERAL	5.00	236,374	240,134	0	1.00
	0		236,374	240,134		

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/28/2015 2:27 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	583,346	11		1.00
	0		0	583,346			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	111,255	0		1.00
	0		0	111,255			
	K - TO RECLASS MRI LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,935	0		1.00
	0		0	4,935			
	L - TO RECLASS MRI BLDG UTILITIES						
1.00	MRI	58.00	0	15,702	0		1.00
	0		0	15,702			
	M - TO RECLASS PHARMACY SALARIES						
1.00	PHARMACY	15.00	803,197	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	0		803,197	0			
	N - TO RECLASS ANESTHESIOLOGY EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	183,053	0		1.00
	TOTALS		0	183,053			
500.00	Grand Total: Decreases		2,569,337	9,688,502			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 9/28/2015 2:27 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	1,449,581	0	0	0	0	1.00
2.00	Land Improvements	1,827,216	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	0	0	0	3.00
4.00	Building Improvements	19,686,815	883,476	0	883,476	1,076,094	4.00
5.00	Fixed Equipment	18,173,061	586,659	0	586,659	124,278	5.00
6.00	Movable Equipment	31,448,347	1,368,611	0	1,368,611	335,423	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	84,170,966	2,838,746	0	2,838,746	1,535,795	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	84,170,966	2,838,746	0	2,838,746	1,535,795	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,449,581	0	1.00
2.00	Land Improvements	1,827,216	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	3.00
4.00	Building Improvements	19,494,197	0	4.00
5.00	Fixed Equipment	18,635,442	0	5.00
6.00	Movable Equipment	32,481,535	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,473,917	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	85,473,917	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 9/28/2015 2:27 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,551,147	1,221	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,317,877	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,869,024	1,221	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	40,452	1,592,820		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,317,877		2.00
3.00	Total (sum of lines 1-2)	40,452	3,910,697		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 9/28/2015 2:27 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	52,992,382	0	52,992,382	0.620010	68,979	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,481,535	3,663	32,477,872	0.379990	42,276	2.00
3.00	Total (sum of lines 1-2)	85,473,917	3,663	85,470,254	1.000000	111,255	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	68,979	1,551,147	1,221	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	42,276	2,125,099	0	2.00
3.00	Total (sum of lines 1-2)	0	0	111,255	3,676,246	1,221	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	582,211	68,979	0	40,452	2,244,010	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	42,276	0	0	2,167,375	2.00
3.00	Total (sum of lines 1-2)	582,211	111,255	0	40,452	4,411,385	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/28/2015 2:27 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,135	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-574,919			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	-4,774,754			0	12.00
13.00	Laundry and linen service	B	-65,884	HOUSEKEEPING	9.00	0	13.00
14.00	Cafeteria-employees and guests	B	-392,817	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-43,416	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MOW & CATERING	B	-165,702	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/28/2015 2:27 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	
33.01	WELLNESS CENTER AND AEROBICS CLASSES	B	-16,689	ELECTROCARDIOLOGY	69.00	0	33.01
33.02	PHYSICIAL THERAPY OTHER INCOME	B	-8,229	PHYSICAL THERAPY	66.00	0	33.02
33.03	EDUCATION REVENUE	B	-7,557	NURSING ADMINISTRATION	13.00	0	33.03
33.04	SICKBAY REVENUE	B	-1,370	ADULTS & PEDIATRICS	30.00	0	33.04
33.05	RADIOLOGY TRANSCRIPT REVENUE	B	-9,554	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	NURSERY OTHER INCOME	B	-887	NURSERY	43.00	0	33.06
33.07	MISCELLANEOUS OTHER INCOME	B	-292	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	ADVERTISING SALARY EXPENSE	A	-164,260	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ADVERTISING EXPENSE	A	-554,896	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTISING BENEFITS	A	-25,151	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	CRNA PURCHASED SERVICES	A	-1,080,934	ANESTHESIOLOGY	53.00	0	33.11
33.12	PAIN MANAGEMENT	B	-27,355	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	BOOK FAIR PROCEEDS	B	-4,034	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	FEDERAL EXCISE TAX	A	-825	PHARMACY	15.00	0	33.14
33.15	SELF INSURANCE EXPENSE	A	-852,814	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	HEALTHLINK FEES	A	39,328	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	MARKETING SUPPLIES	A	-1,493	HOME HEALTH AGENCY	101.00	0	33.17
33.18	PROMOTIONS	A	-1,137	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PUBLIC RELATIONS	A	-9,094	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	PUBLIC RELATIONS	A	-60	DIETARY	10.00	0	33.20
33.21	PUBLIC RELATIONS	A	-7,421	ADULTS & PEDIATRICS	30.00	0	33.21
33.22	PUBLIC RELATIONS	A	-33	OPERATING ROOM	50.00	0	33.22
33.23	PUBLIC RELATIONS	A	-783	RADIOLOGY-DIAGNOSTIC	54.00	0	33.23
33.24	PUBLIC RELATIONS	A	-180	CT SCAN	57.00	0	33.24
33.25	PUBLIC RELATIONS	A	-58	PHYSICAL THERAPY	66.00	0	33.25
33.26	PUBLIC RELATIONS	A	-478	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.26
33.27	PUBLIC RELATIONS	A	-13,602	CLINIC	90.00	0	33.27
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,768,485				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 9/28/2015 2:27 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL REL COSTS- MME	931,369	1,124,147	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE/FINANCE/IS	4,306,374	6,086,406	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PROVIDER TAX HOSPITAL	0	2,720,380	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	394,944	476,508	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,632,687	10,407,441	5.00

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

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

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

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

6.00	B		100.00	PROGRESSIVE HLT	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140120	Period: From 05/01/2014 To 04/30/2015	Worksheet A-8-1 Date/Time Prepared: 9/28/2015 2:27 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-192,778	9		1.00
2.00	-1,780,032	0		2.00
3.00	-2,720,380	0		3.00
4.00	-81,564	0		4.00
5.00	-4,774,754			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HEALTHCARE MGMT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 9/28/2015 2:27 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	76.00	SLEEP LAB	119,250	119,250	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	115,600	115,600	0	0	0	2.00
3.00	60.00	LABORATORY	67,500	67,500	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	281,459	269,459	12,000	154,100	120	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		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			583,809	571,809	12,000		120	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	76.00	SLEEP LAB	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	8,890	445	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		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			8,890	445	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	76.00	SLEEP LAB	0	0	0	119,250		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	115,600		2.00
3.00	60.00	LABORATORY	0	0	0	67,500		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	8,890	3,110	272,569		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		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	8,890	3,110	574,919		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,244,010	2,244,010				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,167,375		2,167,375			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,265,643	9,783	835	5,276,261		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,422,211	647,609	878,998	1,097,653	12,046,471	5.00
7.00	00700	OPERATION OF PLANT	2,051,171	329,232	30,841	101,311	2,512,555	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	250,351	24,800	22,410	33,814	331,375	8.00
9.00	00900	HOUSEKEEPING	1,004,073	1,970	2,798	133,864	1,142,705	9.00
10.00	01000	DIETARY	328,871	47,214	4,498	29,615	410,198	10.00
11.00	01100	CAFETERIA	720,587	13,207	15,872	115,162	864,828	11.00
13.00	01300	NURSING ADMINISTRATION	929,279	63,759	38,331	177,002	1,208,371	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	94,802	34,371	60,614	23,097	212,884	14.00
15.00	01500	PHARMACY	295,182	11,369	12,388	0	318,939	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,052,093	28,409	14,887	128,472	1,223,861	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,493,858	273,729	100,691	1,043,731	6,912,009	30.00
31.00	03100	INTENSIVE CARE UNIT	1,225,411	26,347	52,432	233,883	1,538,073	31.00
43.00	04300	NURSERY	236,772	6,848	6,010	46,054	295,684	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,739,722	137,697	259,934	463,305	3,600,658	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	713,114	22,209	18,034	138,189	891,546	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,680,891	103,458	430,279	250,542	2,465,170	54.00
56.00	05600	RADIOISOTOPE	418,746	5,784	3,063	28,113	455,706	56.00
57.00	05700	CT SCAN	434,739	5,090	4,546	37,094	481,469	57.00
58.00	05800	MRI	183,792	13,431	371	30,105	227,699	58.00
59.00	05900	CARDIAC CATHETERIZATION	279,044	5,057	26,213	42,368	352,682	59.00
60.00	06000	LABORATORY	2,399,880	39,785	57,266	217,833	2,714,764	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	605,018	0	1,208	8,651	614,877	63.00
65.00	06500	RESPIRATORY THERAPY	435,414	10,087	20,037	80,693	546,231	65.00
66.00	06600	PHYSICAL THERAPY	674,799	26,109	2,063	0	702,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	64,008	3,173	58	0	67,239	67.00
68.00	06800	SPEECH PATHOLOGY	127,594	12,215	0	0	139,809	68.00
69.00	06900	ELECTROCARDIOLOGY	445,085	35,204	58,027	79,785	618,101	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,359,188	0	0	0	3,359,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,898,219	0	0	0	1,898,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,809,892	0	0	156,533	2,966,425	73.00
76.00	03610	SLEEP LAB	352	4,891	0	0	5,243	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	489,148	13,359	1,930	64,573	569,010	90.00
91.00	09100	EMERGENCY	2,283,607	97,251	33,930	438,145	2,852,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	736,417	0	8,695	72,984	818,096	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,560,358	2,053,447	2,167,259	5,272,571	55,365,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,983	26,360	116	3,690	50,149	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	120,875	0	0	120,875	192.00
194.00	07950	VACANT SPACE	0	6,517	0	0	6,517	194.00
194.01	07951	LEASED SPACE	0	33,532	0	0	33,532	194.01
194.02	07952	FOUNDATION	0	3,279	0	0	3,279	194.02
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)	55,580,341	2,244,010	2,167,375	5,276,261	55,580,341	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,046,471					5.00
7.00	00700	OPERATION OF PLANT	695,262	3,207,817				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,696	63,270	486,341			8.00
9.00	00900	HOUSEKEEPING	316,204	5,025	29,647	1,493,581		9.00
10.00	01000	DIETARY	113,508	120,452	864	57,303	702,325	10.00
11.00	01100	CAFETERIA	239,311	33,692	0	16,029	0	11.00
13.00	01300	NURSING ADMINISTRATION	334,374	162,661	0	77,383	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,908	87,688	44,579	41,716	0	14.00
15.00	01500	PHARMACY	88,255	29,004	0	13,798	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	338,661	72,477	0	34,480	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,912,652	698,332	117,078	332,223	643,646	30.00
31.00	03100	INTENSIVE CARE UNIT	425,608	67,216	51,059	31,977	58,679	31.00
43.00	04300	NURSERY	81,820	17,470	7,262	8,311	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	996,356	351,290	64,100	167,121	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	246,704	56,660	21,786	26,955	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	682,150	263,940	29,553	125,565	0	54.00
56.00	05600	RADIOISOTOPE	126,101	14,755	0	7,020	0	56.00
57.00	05700	CT SCAN	133,230	12,985	0	6,177	0	57.00
58.00	05800	MRI	63,008	34,266	5,090	16,301	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	97,592	12,900	0	6,137	0	59.00
60.00	06000	LABORATORY	751,216	101,498	8,006	48,286	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	170,146	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	151,150	25,733	0	12,242	0	65.00
66.00	06600	PHYSICAL THERAPY	194,523	66,609	8,222	31,688	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,606	8,094	0	3,851	0	67.00
68.00	06800	SPEECH PATHOLOGY	38,687	31,163	0	14,825	0	68.00
69.00	06900	ELECTROCARDIOLOGY	171,038	89,812	6,278	42,727	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	929,538	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	525,266	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	820,854	0	0	0	0	73.00
76.00	03610	SLEEP LAB	1,451	12,479	105	5,937	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	157,454	34,080	0	16,213	0	90.00
91.00	09100	EMERGENCY	789,449	248,105	70,841	118,033	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	226,379	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,987,157	2,721,656	464,470	1,262,298	702,325	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,877	67,250	0	31,993	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,448	308,374	21,871	146,704	0	192.00
194.00	07950	VACANT SPACE	1,803	16,627	0	7,910	0	194.00
194.01	07951	LEASED SPACE	9,279	85,546	0	40,697	0	194.01
194.02	07952	FOUNDATION	907	8,364	0	3,979	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,046,471	3,207,817	486,341	1,493,581	702,325	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,153,860					11.00
13.00	01300	NURSING ADMINISTRATION	43,804	1,826,593				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,037	0	457,812			14.00
15.00	01500	PHARMACY	0	0	672	450,668		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,004	0	956	0	1,727,439	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	343,734	1,576,016	4,801	379	1,026,557	30.00
31.00	03100	INTENSIVE CARE UNIT	63,843	143,692	267	0	49,889	31.00
43.00	04300	NURSERY	13,097	106,885	138	39	75,160	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	142,219	0	8,808	6,014	369,201	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,291	0	413	117	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,455	0	1,533	1,779	0	54.00
56.00	05600	RADIOISOTOPE	6,429	0	9	58	0	56.00
57.00	05700	CT SCAN	10,395	0	70	0	0	57.00
58.00	05800	MRI	10,532	0	202	2,298	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,541	0	79	19	0	59.00
60.00	06000	LABORATORY	78,137	0	2,028	23	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,112	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	28,587	0	271	19	141,223	65.00
66.00	06600	PHYSICAL THERAPY	0	0	321	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	24,552	0	487	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	274,309	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	154,974	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,059	0	0	436,213	0	73.00
76.00	03610	SLEEP LAB	0	0	29	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,911	0	910	3,577	0	90.00
91.00	09100	EMERGENCY	122,283	0	6,287	83	65,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	154	50	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,151,022	1,826,593	457,718	450,668	1,727,439	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,838	0	94	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,153,860	1,826,593	457,812	450,668	1,727,439	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,567,427	0	13,567,427		30.00
31.00	03100	INTENSIVE CARE UNIT	2,430,303	0	2,430,303		31.00
43.00	04300	NURSERY	605,866	0	605,866		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,705,767	0	5,705,767		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,283,472	0	1,283,472		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,655,145	0	3,655,145		54.00
56.00	05600	RADIOISOTOPE	610,078	0	610,078		56.00
57.00	05700	CT SCAN	644,326	0	644,326		57.00
58.00	05800	MRI	359,396	0	359,396		58.00
59.00	05900	CARDIAC CATHETERIZATION	478,950	0	478,950		59.00
60.00	06000	LABORATORY	3,703,958	0	3,703,958		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	788,135	0	788,135		63.00
65.00	06500	RESPIRATORY THERAPY	905,456	0	905,456		65.00
66.00	06600	PHYSICAL THERAPY	1,004,334	0	1,004,334		66.00
67.00	06700	OCCUPATIONAL THERAPY	97,790	0	97,790		67.00
68.00	06800	SPEECH PATHOLOGY	224,484	0	224,484		68.00
69.00	06900	ELECTROCARDIOLOGY	952,995	0	952,995		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,563,035	0	4,563,035		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,578,459	0	2,578,459		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,257,551	0	4,257,551		73.00
76.00	03610	SLEEP LAB	25,244	0	25,244		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	804,155	0	804,155		90.00
91.00	09100	EMERGENCY	4,273,423	0	4,273,423		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,044,679	0	1,044,679		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,564,428	0	54,564,428		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	166,201	0	166,201		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	631,272	0	631,272		192.00
194.00	07950	VACANT SPACE	32,857	0	32,857		194.00
194.01	07951	LEASED SPACE	169,054	0	169,054		194.01
194.02	07952	FOUNDATION	16,529	0	16,529		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	55,580,341	0	55,580,341		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,783	835	10,618	10,618	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,759	647,609	878,998	1,579,366	2,213	5.00
7.00	00700	OPERATION OF PLANT	7,051	329,232	30,841	367,124	204	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,800	22,410	47,210	68	8.00
9.00	00900	HOUSEKEEPING	0	1,970	2,798	4,768	269	9.00
10.00	01000	DIETARY	0	47,214	4,498	51,712	60	10.00
11.00	01100	CAFETERIA	0	13,207	15,872	29,079	232	11.00
13.00	01300	NURSING ADMINISTRATION	0	63,759	38,331	102,090	356	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,123	34,371	60,614	114,108	46	14.00
15.00	01500	PHARMACY	176,263	11,369	12,388	200,020	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,409	14,887	43,296	258	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,179	273,729	100,691	395,599	2,100	30.00
31.00	03100	INTENSIVE CARE UNIT	5,190	26,347	52,432	83,969	470	31.00
43.00	04300	NURSERY	0	6,848	6,010	12,858	93	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	750	137,697	259,934	398,381	932	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,209	18,034	40,243	278	52.00
53.00	05300	ANESTHESIOLOGY	159	0	0	159	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,851	103,458	430,279	558,588	504	54.00
56.00	05600	RADIOISOTOPE	0	5,784	3,063	8,847	57	56.00
57.00	05700	CT SCAN	0	5,090	4,546	9,636	75	57.00
58.00	05800	MRI	4,935	13,431	371	18,737	61	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,057	26,213	31,270	85	59.00
60.00	06000	LABORATORY	0	39,785	57,266	97,051	438	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,208	1,208	17	63.00
65.00	06500	RESPIRATORY THERAPY	12,676	10,087	20,037	42,800	162	65.00
66.00	06600	PHYSICAL THERAPY	0	26,109	2,063	28,172	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,173	58	3,231	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,215	0	12,215	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	35,204	58,027	93,231	160	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	315	73.00
76.00	03610	SLEEP LAB	0	4,891	0	4,891	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	13,359	1,930	15,289	130	90.00
91.00	09100	EMERGENCY	0	97,251	33,930	131,181	881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	14,000	0	8,695	22,695	147	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	338,936	2,053,447	2,167,259	4,559,642	10,611	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,360	116	26,476	7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	120,875	0	120,875	0	192.00
194.00	07950	VACANT SPACE	0	6,517	0	6,517	0	194.00
194.01	07951	LEASED SPACE	0	33,532	0	33,532	0	194.01
194.02	07952	FOUNDATION	0	3,279	0	3,279	0	194.02
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)	338,936	2,244,010	2,167,375	4,750,321	10,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,581,579					5.00
7.00	00700	OPERATION OF PLANT	91,281	458,609				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,039	9,045	68,362			8.00
9.00	00900	HOUSEKEEPING	41,514	718	4,167	51,436		9.00
10.00	01000	DIETARY	14,902	17,221	121	1,973	85,989	10.00
11.00	01100	CAFETERIA	31,419	4,817	0	552	0	11.00
13.00	01300	NURSING ADMINISTRATION	43,900	23,255	0	2,665	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,734	12,536	6,266	1,437	0	14.00
15.00	01500	PHARMACY	11,587	4,147	0	475	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,463	10,362	0	1,187	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	251,110	99,839	16,459	11,443	78,805	30.00
31.00	03100	INTENSIVE CARE UNIT	55,878	9,610	7,177	1,101	7,184	31.00
43.00	04300	NURSERY	10,742	2,498	1,021	286	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	130,812	50,223	9,010	5,755	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,390	8,100	3,062	928	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,560	37,734	4,154	4,324	0	54.00
56.00	05600	RADIOISOTOPE	16,556	2,109	0	242	0	56.00
57.00	05700	CT SCAN	17,492	1,856	0	213	0	57.00
58.00	05800	MRI	8,272	4,899	715	561	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,813	1,844	0	211	0	59.00
60.00	06000	LABORATORY	98,627	14,511	1,125	1,663	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	22,338	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	19,845	3,679	0	422	0	65.00
66.00	06600	PHYSICAL THERAPY	25,539	9,523	1,156	1,091	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,443	1,157	0	133	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,079	4,455	0	511	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,456	12,840	882	1,471	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	122,039	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,962	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,770	0	0	0	0	73.00
76.00	03610	SLEEP LAB	190	1,784	15	204	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,672	4,872	0	558	0	90.00
91.00	09100	EMERGENCY	103,647	35,471	9,958	4,065	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	29,721	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,573,792	389,105	65,288	43,471	85,989	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,822	9,614	0	1,102	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,391	44,087	3,074	5,052	0	192.00
194.00	07950	VACANT SPACE	237	2,377	0	272	0	194.00
194.01	07951	LEASED SPACE	1,218	12,230	0	1,402	0	194.01
194.02	07952	FOUNDATION	119	1,196	0	137	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,581,579	458,609	68,362	51,436	85,989	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	66,099					11.00
13.00	01300	NURSING ADMINISTRATION	2,509	174,775				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	690	0	142,817			14.00
15.00	01500	PHARMACY	0	0	210	216,439		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,265	0	298	0	103,129	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,692	150,799	1,498	182	61,286	30.00
31.00	03100	INTENSIVE CARE UNIT	3,657	13,749	83	0	2,978	31.00
43.00	04300	NURSERY	750	10,227	43	19	4,487	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,147	0	2,748	2,888	22,042	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,251	0	129	56	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,895	0	478	855	0	54.00
56.00	05600	RADIOISOTOPE	368	0	3	28	0	56.00
57.00	05700	CT SCAN	596	0	22	0	0	57.00
58.00	05800	MRI	603	0	63	1,104	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	547	0	25	9	0	59.00
60.00	06000	LABORATORY	4,476	0	633	11	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	178	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,638	0	85	9	8,431	65.00
66.00	06600	PHYSICAL THERAPY	0	0	100	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	1,406	0	152	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	85,570	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	48,346	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,951	0	0	209,496	0	73.00
76.00	03610	SLEEP LAB	0	0	9	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,312	0	284	1,718	0	90.00
91.00	09100	EMERGENCY	7,005	0	1,961	40	3,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	48	24	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,936	174,775	142,788	216,439	103,129	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	163	0	29	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	66,099	174,775	142,817	216,439	103,129	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,088,812	0	1,088,812		30.00
31.00	03100	INTENSIVE CARE UNIT	185,856	0	185,856		31.00
43.00	04300	NURSERY	43,024	0	43,024		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	630,938	0	630,938		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,437	0	87,437		52.00
53.00	05300	ANESTHESIOLOGY	159	0	159		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	701,092	0	701,092		54.00
56.00	05600	RADIOISOTOPE	28,210	0	28,210		56.00
57.00	05700	CT SCAN	29,890	0	29,890		57.00
58.00	05800	MRI	35,015	0	35,015		58.00
59.00	05900	CARDIAC CATHETERIZATION	46,804	0	46,804		59.00
60.00	06000	LABORATORY	218,535	0	218,535		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,741	0	23,741		63.00
65.00	06500	RESPIRATORY THERAPY	77,071	0	77,071		65.00
66.00	06600	PHYSICAL THERAPY	65,581	0	65,581		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,964	0	6,964		67.00
68.00	06800	SPEECH PATHOLOGY	22,260	0	22,260		68.00
69.00	06900	ELECTROCARDIOLOGY	132,598	0	132,598		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	207,609	0	207,609		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,308	0	117,308		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	319,532	0	319,532		73.00
76.00	03610	SLEEP LAB	7,093	0	7,093		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	44,835	0	44,835		90.00
91.00	09100	EMERGENCY	298,114	0	298,114		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	52,635	0	52,635		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,471,113	0	4,471,113		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,213	0	39,213		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	177,479	0	177,479		192.00
194.00	07950	VACANT SPACE	9,403	0	9,403		194.00
194.01	07951	LEASED SPACE	48,382	0	48,382		194.01
194.02	07952	FOUNDATION	4,731	0	4,731		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,750,321	0	4,750,321		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	CAP REL COSTS-BLDG & FIXT	339,493					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,125,099				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,480	819	26,205,996			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	97,976	861,855	5,451,802	-12,046,471	43,533,870	5.00
7.00	00700	OPERATION OF PLANT	49,809	30,239	503,190	0	2,512,555	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	21,973	167,945	0	331,375	8.00
9.00	00900	HOUSEKEEPING	298	2,743	664,870	0	1,142,705	9.00
10.00	01000	DIETARY	7,143	4,410	147,090	0	410,198	10.00
11.00	01100	CAFETERIA	1,998	15,562	571,984	0	864,828	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	37,583	879,127	0	1,208,371	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	59,432	114,720	0	212,884	14.00
15.00	01500	PHARMACY	1,720	12,146	0	0	318,939	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	14,597	638,092	0	1,223,861	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	98,727	5,183,976	0	6,912,009	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	51,409	1,161,643	0	1,538,073	31.00
43.00	04300	NURSERY	1,036	5,893	228,739	0	295,684	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	254,864	2,301,130	0	3,600,658	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	17,682	686,352	0	891,546	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	421,886	1,244,384	0	2,465,170	54.00
56.00	05600	RADIOISOTOPE	875	3,003	139,632	0	455,706	56.00
57.00	05700	CT SCAN	770	4,457	184,235	0	481,469	57.00
58.00	05800	MRI	2,032	364	149,524	0	227,699	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	25,702	210,432	0	352,682	59.00
60.00	06000	LABORATORY	6,019	56,149	1,081,928	0	2,714,764	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,184	42,970	0	614,877	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	19,646	400,784	0	546,231	65.00
66.00	06600	PHYSICAL THERAPY	3,950	2,023	0	0	702,971	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	57	0	0	67,239	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	0	0	139,809	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	56,895	396,275	0	618,101	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,359,188	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,898,219	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	777,466	0	2,966,425	73.00
76.00	03610	SLEEP LAB	740	0	0	0	5,243	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	1,892	320,717	0	569,010	90.00
91.00	09100	EMERGENCY	14,713	33,268	2,176,165	0	2,852,933	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,525	362,496	0	818,096	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,663	2,124,985	26,187,668	-12,046,471	43,319,518	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	114	18,328	0	50,149	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	0	0	120,875	192.00
194.00	07950	VACANT SPACE	986	0	0	0	6,517	194.00
194.01	07951	LEASED SPACE	5,073	0	0	0	33,532	194.01
194.02	07952	FOUNDATION	496	0	0	0	3,279	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,244,010	2,167,375	5,276,261		12,046,471	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.609886	1.019894	0.201338		0.276715	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			10,618		1,581,579	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000405		0.036330	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	190,228					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	675,455				8.00
9.00	00900	HOUSEKEEPING	298	41,175	186,178			9.00
10.00	01000	DIETARY	7,143	1,200	7,143	57,188		10.00
11.00	01100	CAFETERIA	1,998	0	1,998	0	33,743	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	0	9,646	0	1,281	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	61,913	5,200	0	352	14.00
15.00	01500	PHARMACY	1,720	0	1,720	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	0	4,298	0	1,667	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	162,607	41,412	52,410	10,052	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	70,913	3,986	4,778	1,867	31.00
43.00	04300	NURSERY	1,036	10,086	1,036	0	383	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	89,025	20,832	0	4,159	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	30,257	3,360	0	1,149	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	41,044	15,652	0	2,499	54.00
56.00	05600	RADIOISOTOPE	875	0	875	0	188	56.00
57.00	05700	CT SCAN	770	0	770	0	304	57.00
58.00	05800	MRI	2,032	7,069	2,032	0	308	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	0	765	0	279	59.00
60.00	06000	LABORATORY	6,019	11,119	6,019	0	2,285	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	91	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	0	1,526	0	836	65.00
66.00	06600	PHYSICAL THERAPY	3,950	11,419	3,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	0	480	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	1,848	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	8,719	5,326	0	718	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	996	73.00
76.00	03610	SLEEP LAB	740	146	740	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	0	2,021	0	670	90.00
91.00	09100	EMERGENCY	14,713	98,388	14,713	0	3,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	161,398	645,080	157,348	57,188	33,660	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	3,988	0	83	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	30,375	18,287	0	0	192.00
194.00	07950	VACANT SPACE	986	0	986	0	0	194.00
194.01	07951	LEASED SPACE	5,073	0	5,073	0	0	194.01
194.02	07952	FOUNDATION	496	0	496	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,207,817	486,341	1,493,581	702,325	1,153,860	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.863012	0.720020	8.022328	12.280986	34.195537	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	458,609	68,362	51,436	85,989	66,099	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.410839	0.101209	0.276273	1.503620	1.958895	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/28/2015 2:27 pm

		Cost Center Description	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	15,483					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,607,541				14.00
15.00	01500	PHARMACY	0	8,229	2,099,781			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,715	0	29,051		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,359	58,804	1,768	17,264		30.00
31.00	03100	INTENSIVE CARE UNIT	1,218	3,271	0	839		31.00
43.00	04300	NURSERY	906	1,688	182	1,264		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	107,889	28,021	6,209		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,063	547	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,777	8,290	0		54.00
56.00	05600	RADIOISOTOPE	0	109	271	0		56.00
57.00	05700	CT SCAN	0	856	0	0		57.00
58.00	05800	MRI	0	2,469	10,706	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	965	90	0		59.00
60.00	06000	LABORATORY	0	24,840	106	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	3,324	87	2,375		65.00
66.00	06600	PHYSICAL THERAPY	0	3,937	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,964	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,359,883	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,898,219	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,032,426	0		73.00
76.00	03610	SLEEP LAB	0	352	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,141	16,666	0		90.00
91.00	09100	EMERGENCY	0	77,002	386	1,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,887	235	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,483	5,606,384	2,099,781	29,051		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,157	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	VACANT SPACE	0	0	0	0		194.00
194.01	07951	LEASED SPACE	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,826,593	457,812	450,668	1,727,439		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	117.974101	0.081642	0.214626	59.462290		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	174,775	142,817	216,439	103,129		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.288187	0.025469	0.103077	3.549929		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/28/2015 2:27 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,567,427		13,567,427	0	13,567,427	30.00
31.00	03100	INTENSIVE CARE UNIT	2,430,303		2,430,303	0	2,430,303	31.00
43.00	04300	NURSERY	605,866		605,866	0	605,866	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,705,767		5,705,767	0	5,705,767	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,283,472		1,283,472	0	1,283,472	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,655,145		3,655,145	0	3,655,145	54.00
56.00	05600	RADIOISOTOPE	610,078		610,078	0	610,078	56.00
57.00	05700	CT SCAN	644,326		644,326	0	644,326	57.00
58.00	05800	MRI	359,396		359,396	0	359,396	58.00
59.00	05900	CARDIAC CATHETERIZATION	478,950		478,950	0	478,950	59.00
60.00	06000	LABORATORY	3,703,958		3,703,958	0	3,703,958	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	788,135		788,135	0	788,135	63.00
65.00	06500	RESPIRATORY THERAPY	905,456	0	905,456	0	905,456	65.00
66.00	06600	PHYSICAL THERAPY	1,004,334	0	1,004,334	0	1,004,334	66.00
67.00	06700	OCCUPATIONAL THERAPY	97,790	0	97,790	0	97,790	67.00
68.00	06800	SPEECH PATHOLOGY	224,484	0	224,484	0	224,484	68.00
69.00	06900	ELECTROCARDIOLOGY	952,995		952,995	3,110	956,105	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,563,035		4,563,035	0	4,563,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,578,459		2,578,459	0	2,578,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,257,551		4,257,551	0	4,257,551	73.00
76.00	03610	SLEEP LAB	25,244		25,244	0	25,244	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	804,155		804,155	0	804,155	90.00
91.00	09100	EMERGENCY	4,273,423		4,273,423	0	4,273,423	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,919,916		1,919,916		1,919,916	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,044,679		1,044,679		1,044,679	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	56,484,344	0	56,484,344	3,110	56,487,454	200.00
201.00		Less Observation Beds	1,919,916		1,919,916		1,919,916	201.00
202.00		Total (see instructions)	54,564,428	0	54,564,428	3,110	54,567,538	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/28/2015 2:27 pm

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		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	21,806,203		21,806,203			30.00
31.00	03100	INTENSIVE CARE UNIT	3,635,833		3,635,833			31.00
43.00	04300	NURSERY	867,164		867,164			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,302,057	35,571,928	45,873,985	0.124379	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,240,382	362,140	2,602,522	0.493165	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,713,214	15,481,063	19,194,277	0.190429	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,022,564	5,626,908	6,649,472	0.091748	0.000000	56.00
57.00	05700	CT SCAN	4,753,336	20,011,308	24,764,644	0.026018	0.000000	57.00
58.00	05800	MRI	749,994	6,251,107	7,001,101	0.051334	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	940,634	1,045,949	1,986,583	0.241092	0.000000	59.00
60.00	06000	LABORATORY	10,192,544	19,306,312	29,498,856	0.125563	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	758,558	413,080	1,171,638	0.672678	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	3,985,558	320,922	4,306,480	0.210254	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,609,334	1,619,490	3,228,824	0.311053	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,776	105,603	286,379	0.341471	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	184,358	139,354	323,712	0.693468	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,135,516	7,150,628	10,286,144	0.092648	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,421,654	3,500,799	10,922,453	0.417767	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,012,254	1,880,235	5,892,489	0.437584	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,016,776	10,473,123	23,489,899	0.181250	0.000000	73.00
76.00	03610	SLEEP LAB	0	1,492,140	1,492,140	0.016918	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	18,838	2,790,227	2,809,065	0.286271	0.000000	90.00
91.00	09100	EMERGENCY	5,111,792	26,005,241	31,117,033	0.137334	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	426,148	2,737,882	3,164,030	0.606794	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,482,019	1,482,019			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	100,085,487	163,767,458	263,852,945			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	100,085,487	163,767,458	263,852,945			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/28/2015 2:27 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.124379	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.493165	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190429	54.00
56.00	05600	RADIOISOTOPE	0.091748	56.00
57.00	05700	CT SCAN	0.026018	57.00
58.00	05800	MRI	0.051334	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.241092	59.00
60.00	06000	LABORATORY	0.125563	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.672678	63.00
65.00	06500	RESPIRATORY THERAPY	0.210254	65.00
66.00	06600	PHYSICAL THERAPY	0.311053	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341471	67.00
68.00	06800	SPEECH PATHOLOGY	0.693468	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.417767	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.437584	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181250	73.00
76.00	03610	SLEEP LAB	0.016918	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.286271	90.00
91.00	09100	EMERGENCY	0.137334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.606794	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part I | Date/Time Prepared: 9/28/2015 2:27 pm

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	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	1,088,812	0	1,088,812	15,370	70.84	30.00
31.00	INTENSIVE CARE UNIT	185,856		185,856	1,215	152.97	31.00
43.00	NURSERY	43,024		43,024	884	48.67	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,317,692		1,317,692	17,469		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	6,845	484,900				30.00
31.00	INTENSIVE CARE UNIT	616	94,230				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30-199)	7,461	579,130				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part II Date/Time Prepared: 9/28/2015 2:27 pm

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		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	630,938	45,873,985	0.013754	4,923,484	67,718	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,437	2,602,522	0.033597	16,460	553	52.00
53.00	05300	ANESTHESIOLOGY	159	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	701,092	19,194,277	0.036526	2,087,324	76,242	54.00
56.00	05600	RADIOISOTOPE	28,210	6,649,472	0.004242	678,003	2,876	56.00
57.00	05700	CT SCAN	29,890	24,764,644	0.001207	2,626,171	3,170	57.00
58.00	05800	MRI	35,015	7,001,101	0.005001	370,718	1,854	58.00
59.00	05900	CARDIAC CATHETERIZATION	46,804	1,986,583	0.023560	534,260	12,587	59.00
60.00	06000	LABORATORY	218,535	29,498,856	0.007408	5,383,496	39,881	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,741	1,171,638	0.020263	462,908	9,380	63.00
65.00	06500	RESPIRATORY THERAPY	77,071	4,306,480	0.017897	2,348,924	42,039	65.00
66.00	06600	PHYSICAL THERAPY	65,581	3,228,824	0.020311	969,398	19,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,964	286,379	0.024317	99,701	2,424	67.00
68.00	06800	SPEECH PATHOLOGY	22,260	323,712	0.068765	148,893	10,239	68.00
69.00	06900	ELECTROCARDIOLOGY	132,598	10,286,144	0.012891	1,870,604	24,114	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	207,609	10,922,453	0.019008	4,157,462	79,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	117,308	5,892,489	0.019908	2,060,611	41,023	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	319,532	23,489,899	0.013603	6,629,849	90,186	73.00
76.00	03610	SLEEP LAB	7,093	1,492,140	0.004754	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	44,835	2,809,065	0.015961	13,671	218	90.00
91.00	09100	EMERGENCY	298,114	31,117,033	0.009580	2,792,004	26,747	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	154,077	3,164,030	0.048696	266,270	12,966	92.00
200.00		Total (lines 50-199)	3,254,863	236,061,726		38,440,211	562,931	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part III Date/Time Prepared: 9/28/2015 2:27 pm

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
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	15,370	0.00	6,845	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,215	0.00	616	0		31.00
43.00	04300	NURSERY	884	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	17,469		7,461	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/28/2015 2:27 pm

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		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/28/2015 2:27 pm

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		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	45,873,985	0.000000	0.000000	4,923,484	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,602,522	0.000000	0.000000	16,460	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,194,277	0.000000	0.000000	2,087,324	54.00
56.00	05600	RADIOISOTOPE	0	6,649,472	0.000000	0.000000	678,003	56.00
57.00	05700	CT SCAN	0	24,764,644	0.000000	0.000000	2,626,171	57.00
58.00	05800	MRI	0	7,001,101	0.000000	0.000000	370,718	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,986,583	0.000000	0.000000	534,260	59.00
60.00	06000	LABORATORY	0	29,498,856	0.000000	0.000000	5,383,496	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,171,638	0.000000	0.000000	462,908	63.00
65.00	06500	RESPIRATORY THERAPY	0	4,306,480	0.000000	0.000000	2,348,924	65.00
66.00	06600	PHYSICAL THERAPY	0	3,228,824	0.000000	0.000000	969,398	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	286,379	0.000000	0.000000	99,701	67.00
68.00	06800	SPEECH PATHOLOGY	0	323,712	0.000000	0.000000	148,893	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,286,144	0.000000	0.000000	1,870,604	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,922,453	0.000000	0.000000	4,157,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,892,489	0.000000	0.000000	2,060,611	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,489,899	0.000000	0.000000	6,629,849	73.00
76.00	03610	SLEEP LAB	0	1,492,140	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,809,065	0.000000	0.000000	13,671	90.00
91.00	09100	EMERGENCY	0	31,117,033	0.000000	0.000000	2,792,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,164,030	0.000000	0.000000	266,270	92.00
200.00		Total (lines 50-199)	0	236,061,726			38,440,211	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/28/2015 2:27 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	8,357,101	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,486,413	0		54.00
56.00	05600	RADIOISOTOPE	0	1,937,169	0		56.00
57.00	05700	CT SCAN	0	6,834,817	0		57.00
58.00	05800	MRI	0	1,702,940	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	598,171	0		59.00
60.00	06000	LABORATORY	0	2,516,949	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	226,874	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	104,778	0		65.00
66.00	06600	PHYSICAL THERAPY	0	170	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	2,548,094	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	772,747	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	806,691	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,347,567	0		73.00
76.00	03610	SLEEP LAB	0	447,190	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	571,004	0		90.00
91.00	09100	EMERGENCY	0	3,960,798	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	726,440	0		92.00
200.00		Total (lines 50-199)	0	38,945,913	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/28/2015 2:27 pm

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		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	0.124379	8,357,101	0	0	1,039,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.493165	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190429	3,486,413	0	0	663,914	54.00
56.00	05600	RADIOISOTOPE	0.091748	1,937,169	0	0	177,731	56.00
57.00	05700	CT SCAN	0.026018	6,834,817	0	0	177,828	57.00
58.00	05800	MRI	0.051334	1,702,940	0	0	87,419	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.241092	598,171	0	0	144,214	59.00
60.00	06000	LABORATORY	0.125563	2,516,949	33,665	0	316,036	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.672678	226,874	0	0	152,613	63.00
65.00	06500	RESPIRATORY THERAPY	0.210254	104,778	0	0	22,030	65.00
66.00	06600	PHYSICAL THERAPY	0.311053	170	0	0	53	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341471	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.693468	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092648	2,548,094	0	0	236,076	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.417767	772,747	0	0	322,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.437584	806,691	38,125	0	352,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181250	3,347,567	0	20,100	606,747	73.00
76.00	03610	SLEEP LAB	0.016918	447,190	0	0	7,566	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.286271	571,004	0	0	163,462	90.00
91.00	09100	EMERGENCY	0.137334	3,960,798	0	0	543,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.606794	726,440	0	0	440,799	92.00
200.00		Subtotal (see instructions)		38,945,913	71,790	20,100	5,455,711	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		38,945,913	71,790	20,100	5,455,711	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/28/2015 2:27 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	4,227	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,683	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,643		73.00
76.00	03610	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	20,910	3,643		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	20,910	3,643		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/28/2015 2:27 pm

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	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)	15,370	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,370	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)	13,195	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)	6,845	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)	13,567,427	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)	13,567,427	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)	13,567,427	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)	882.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,042,218	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)	6,042,218	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/28/2015 2:27 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,430,303	1,215	2,000.25	616	1,232,154	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)	7,779,407	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,053,779	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)	579,130	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	562,931	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,142,061	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,911,718	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)	2,175	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	882.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,919,916	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/28/2015 2:27 pm

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	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	1,088,812	13,567,427	0.080252	1,919,916	154,077	90.00
91.00	Nursing School cost	0	13,567,427	0.000000	1,919,916	0	91.00
92.00	Allied health cost	0	13,567,427	0.000000	1,919,916	0	92.00
93.00	All other Medical Education	0	13,567,427	0.000000	1,919,916	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/28/2015 2:27 pm

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		10,816,658		30.00
31.00	03100	INTENSIVE CARE UNIT		1,750,156		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.124379	4,923,484	612,378	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.493165	16,460	8,117	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.190429	2,087,324	397,487	54.00
56.00	05600	RADIOISOTOPE	0.091748	678,003	62,205	56.00
57.00	05700	CT SCAN	0.026018	2,626,171	68,328	57.00
58.00	05800	MRI	0.051334	370,718	19,030	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.241092	534,260	128,806	59.00
60.00	06000	LABORATORY	0.125563	5,383,496	675,968	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.672678	462,908	311,388	63.00
65.00	06500	RESPIRATORY THERAPY	0.210254	2,348,924	493,871	65.00
66.00	06600	PHYSICAL THERAPY	0.311053	969,398	301,534	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.341471	99,701	34,045	67.00
68.00	06800	SPEECH PATHOLOGY	0.693468	148,893	103,253	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092951	1,870,604	173,875	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.417767	4,157,462	1,736,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.437584	2,060,611	901,690	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181250	6,629,849	1,201,660	73.00
76.00	03610	SLEEP LAB	0.016918	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.286271	13,671	3,914	90.00
91.00	09100	EMERGENCY	0.137334	2,792,004	383,437	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.606794	266,270	161,571	92.00
200.00		Total (sum of lines 50-94 and 96-98)		38,440,211	7,779,407	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)		38,440,211		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/28/2015 2:27 pm

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER 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)		9,405,605			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0			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)		243,124			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)		101.04			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/28/2015 2:27 pm

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.41			30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.12			31.00
32.00	Sum of lines 30 and 31		19.53			32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.44			33.00
34.00	Disproportionate share adjustment (see instructions)		127,916			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000076311		0.000079184	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		690,341		605,571	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		289,376		351,729	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		641,105			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		10,417,750			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)		10,417,750			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		793,685			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)		11,211,435			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,211,435			61.00
62.00	Deductibles billed to program beneficiaries		1,369,936			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/28/2015 2:27 pm

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		7,516			63.00
64.00	Allowable bad debts (see instructions)		213,861			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		139,010			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		153,074			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,972,993			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)		-18,003			70.93
70.94	HRR adjustment amount (see instructions)		-190,658			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,764,332			71.00
71.01	Sequestration adjustment (see instructions)		195,287			71.01
72.00	Interim payments		9,547,778			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)		21,267			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		10,348			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part A Date/Time Prepared: 9/28/2015 2:27 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0		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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part B Date/Time Prepared: 9/28/2015 2:27 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	24,553	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,455,711	2.00
3.00	PPS payments	5,366,659	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	24,553	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	91,890	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)	91,890	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)	91,890	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	67,337	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)	24,553	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)	5,366,659	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	7,625	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,235,741	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)	4,147,846	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)	4,147,846	30.00
31.00	Primary payer payments	1,306	31.00
32.00	Subtotal (line 30 minus line 31)	4,146,540	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)	182,092	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	118,360	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	135,359	36.00
37.00	Subtotal (see instructions)	4,264,900	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,264,900	40.00
40.01	Sequestration adjustment (see instructions)	85,298	40.01
41.00	Interim payments	4,237,516	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-57,914	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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

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		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		9,538,355		4,218,469	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	11/20/2014	9,423	11/20/2014	19,047	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)		9,423		19,047	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)		9,547,778		4,237,516	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		21,267		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		57,914	6.02
7.00	Total Medicare program liability (see instructions)		9,569,045		4,179,602	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: 140120	Period: From 05/01/2014 To 04/30/2015	Worksheet E-1 Part II Date/Time Prepared: 9/28/2015 2:27 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	3,527	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	7,461	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,446	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	14,410	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	263,852,945	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	661,848	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)	853,092	8.00
9.00	Sequestration adjustment amount (see instructions)	17,062	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	836,030	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	826,788	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)	9,242	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G | Date/Time Prepared: 9/28/2015 2:27 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	6,994,617	0	0	0	1.00
2.00	Temporary investments	500,998	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	15,004,150	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,874,000	0	0	0	6.00
7.00	Inventory	1,066,150	0	0	0	7.00
8.00	Prepaid expenses	2,479,847	0	0	0	8.00
9.00	Other current assets	243,005	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)	21,414,767	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,449,581	0	0	0	12.00
13.00	Land improvements	1,827,216	0	0	0	13.00
14.00	Accumulated depreciation	-1,699,389	0	0	0	14.00
15.00	Buildings	11,585,946	0	0	0	15.00
16.00	Accumulated depreciation	-8,982,257	0	0	0	16.00
17.00	Leasehold improvements	19,494,196	0	0	0	17.00
18.00	Accumulated depreciation	-14,725,759	0	0	0	18.00
19.00	Fixed equipment	18,635,442	0	0	0	19.00
20.00	Accumulated depreciation	-12,715,657	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	31,289,791	0	0	0	23.00
24.00	Accumulated depreciation	-23,927,325	0	0	0	24.00
25.00	Minor equipment depreciable	1,191,744	0	0	0	25.00
26.00	Accumulated depreciation	-995,376	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	720,650	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,148,803	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	23,633,342	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	3,143,443	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,776,785	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,340,355	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,429,136	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,511,025	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	3,699,353	0	0	0	43.00
44.00	Other current liabilities	4,676,639	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,316,153	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,024,947	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,079,491	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	19,104,438	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	33,420,591	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	37,919,764				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)	37,919,764	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,340,355	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-1 | Date/Time Prepared: 9/28/2015 2:27 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		38,431,845		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,013,500				2.00
3.00	Total (sum of line 1 and line 2)		45,445,345		0		3.00
4.00	CAPITAL CONTRIBUTION	49,000		0		0	4.00
5.00	CHANGE IN RESTRICTED ASSETS	36,793		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)		85,793		0		10.00
11.00	Subtotal (line 3 plus line 10)		45,531,138		0		11.00
12.00	CHANGES IN MINIMUM PENSION LIABILITY	3,654,386		0		0	12.00
13.00	TRANSFER TO AFFILIATES	3,956,988		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)		7,611,374		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		37,919,764		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	CAPITAL CONTRIBUTION		0		4.00
5.00	CHANGE IN RESTRICTED ASSETS		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	CHANGES IN MINIMUM PENSION LIABILITY		0		12.00
13.00	TRANSFER TO AFFILIATES		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: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/28/2015 2:27 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,871,710		22,871,710	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	22,871,710		22,871,710	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,645,518		3,645,518	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,645,518		3,645,518	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	26,517,228		26,517,228	17.00
18.00	Ancillary services	68,969,283	132,003,190	200,972,473	18.00
19.00	Outpatient services	5,556,778	31,735,747	37,292,525	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,482,019	1,482,019	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	295,967	610,153	906,120	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	101,339,256	165,831,109	267,170,365	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		64,348,826		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		64,348,826		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-3 | Date/Time Prepared: 9/28/2015 2:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	267,170,365	1.00
2.00	Less contractual allowances and discounts on patients' accounts	199,151,788	2.00
3.00	Net patient revenues (line 1 minus line 2)	68,018,577	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	64,348,826	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,669,751	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	21,257	6.00
7.00	Income from investments	1,499,465	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	65,884	13.00
14.00	Revenue from meals sold to employees and guests	558,519	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	43,416	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	26,548	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENTS	446,805	24.00
24.01	WELLNESS CENTER	16,689	24.01
24.02	INVESTMENT INCOME ON SI TRUST	55,348	24.02
24.03	MISCELLANEOUS INCOME	59,278	24.03
24.04	EHR FUNDS	582,593	24.04
25.00	Total other income (sum of lines 6-24)	3,375,802	25.00
26.00	Total (line 5 plus line 25)	7,045,553	26.00
27.00	LOSS ON ASSET DISPOSAL	32,053	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	32,053	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,013,500	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H | Date/Time Prepared: 9/28/2015 2:27 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		14,000	14,000	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	6,311	6,311	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	111,158	0	14,618	2,894	39,876	168,546	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	248,005	0	0	0	0	248,005	6.00
7.00	Physical Therapy	0	0	0	239,085	0	239,085	7.00
8.00	Occupational Therapy	0	0	0	46,661	0	46,661	8.00
9.00	Speech Pathology	0	0	0	8,652	0	8,652	9.00
10.00	Medical Social Services	97	0	0	0	0	97	10.00
11.00	Home Health Aide	3,146	0	0	0	0	3,146	11.00
12.00	Supplies (see instructions)	0	0	0	3,600	4,749	8,349	12.00
13.00	Drugs	0	0	0	0	235	235	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)	362,406	0	14,618	300,892	65,171	743,087	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	14,000	0	14,000			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	6,311	0	6,311			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-519	168,027	-1,492	166,535			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	248,005	0	248,005			6.00
7.00	Physical Therapy	0	239,085	0	239,085			7.00
8.00	Occupational Therapy	0	46,661	0	46,661			8.00
9.00	Speech Pathology	0	8,652	0	8,652			9.00
10.00	Medical Social Services	0	97	0	97			10.00
11.00	Home Health Aide	0	3,146	0	3,146			11.00
12.00	Supplies (see instructions)	-4,749	3,600	0	3,600			12.00
13.00	Drugs	90	325	0	325			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)	-5,178	737,909	-1,492	736,417			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: 140120 | HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-1 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	14,000	14,000				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	6,311	0	0	6,311		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	166,535	14,000	0	6,311	0	186,846	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	248,005	0	0	0	0	248,005	6.00
7.00	Physical Therapy	239,085	0	0	0	0	239,085	7.00
8.00	Occupational Therapy	46,661	0	0	0	0	46,661	8.00
9.00	Speech Pathology	8,652	0	0	0	0	8,652	9.00
10.00	Medical Social Services	97	0	0	0	0	97	10.00
11.00	Home Health Aide	3,146	0	0	0	0	3,146	11.00
12.00	Supplies (see instructions)	3,600	0	0	0	0	3,600	12.00
13.00	Drugs	325	0	0	0		325	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)	736,417	14,000	0	6,311	0	736,417	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	186,846		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	84,318	332,323	6.00
7.00	Physical Therapy	81,285	320,370	7.00
8.00	Occupational Therapy	15,864	62,525	8.00
9.00	Speech Pathology	2,942	11,594	9.00
10.00	Medical Social Services	33	130	10.00
11.00	Home Health Aide	1,070	4,216	11.00
12.00	Supplies (see instructions)	1,224	4,824	12.00
13.00	Drugs	110	435	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)		736,417	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-1 Part II Date/Time Prepared: 9/28/2015 2:27 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	2,000				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	2,000		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	2,000	0	2,000	0	-186,846	549,571	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	248,005	6.00
7.00	Physical Therapy	0	0	0	0	0	239,085	7.00
8.00	Occupational Therapy	0	0	0	0	0	46,661	8.00
9.00	Speech Pathology	0	0	0	0	0	8,652	9.00
10.00	Medical Social Services	0	0	0	0	0	97	10.00
11.00	Home Health Aide	0	0	0	0	0	3,146	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	3,600	12.00
13.00	Drugs	0	0	0		0	325	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)	2,000	0	2,000	0	-186,846	549,571	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	14,000	0	6,311	0		186,846	25.00
26.00	Unit Cost Multiplier	7.000000	0.000000	3.155500	0.000000		0.339985	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	8,695	22,380	31,075	8,599	1.00
2.00	Skilled Nursing Care	332,323	0	0	49,933	382,256	105,775	2.00
3.00	Physical Therapy	320,370	0	0	0	320,370	88,651	3.00
4.00	Occupational Therapy	62,525	0	0	0	62,525	17,302	4.00
5.00	Speech Pathology	11,594	0	0	0	11,594	3,208	5.00
6.00	Medical Social Services	130	0	0	20	150	42	6.00
7.00	Home Health Aide	4,216	0	0	633	4,849	1,342	7.00
8.00	Supplies (see instructions)	4,824	0	0	0	4,824	1,335	8.00
9.00	Drugs	435	0	0	18	453	125	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)	736,417	0	8,695	72,984	818,096	226,379	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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	154	0	0	39,828	0	39,828	1.00
2.00	Skilled Nursing Care	0	0	0	488,031	0	488,031	2.00
3.00	Physical Therapy	0	0	0	409,021	0	409,021	3.00
4.00	Occupational Therapy	0	0	0	79,827	0	79,827	4.00
5.00	Speech Pathology	0	0	0	14,802	0	14,802	5.00
6.00	Medical Social Services	0	0	0	192	0	192	6.00
7.00	Home Health Aide	0	0	0	6,191	0	6,191	7.00
8.00	Supplies (see instructions)	0	0	0	6,159	0	6,159	8.00
9.00	Drugs	0	50	0	628	0	628	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)	154	50	0	1,044,679	0	1,044,679	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	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	19,343	507,374	2.00
3.00	Physical Therapy	16,212	425,233	3.00
4.00	Occupational Therapy	3,164	82,991	4.00
5.00	Speech Pathology	587	15,389	5.00
6.00	Medical Social Services	8	200	6.00
7.00	Home Health Aide	245	6,436	7.00
8.00	Supplies (see instructions)	244	6,403	8.00
9.00	Drugs	25	653	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	39,828	1,044,679	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.	0.039636		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: 140120 HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-2 Part II Date/Time Prepared: 9/28/2015 2:27 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	8,525	111,158	0	31,075	0	1.00
2.00	Skilled Nursing Care	0	0	248,005	0	382,256	0	2.00
3.00	Physical Therapy	0	0	0	0	320,370	0	3.00
4.00	Occupational Therapy	0	0	0	0	62,525	0	4.00
5.00	Speech Pathology	0	0	0	0	11,594	0	5.00
6.00	Medical Social Services	0	0	97	0	150	0	6.00
7.00	Home Health Aide	0	0	3,146	0	4,849	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	4,824	0	8.00
9.00	Drugs	0	0	90	0	453	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	8,525	362,496		818,096	0	20.00
21.00	Total cost to be allocated	0	8,695	72,984		226,379	0	21.00
22.00	Unit cost multiplier	0.000000	1.019941	0.201337		0.276714	0.000000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	0	1,887	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	0	1,887	20.00
21.00	Total cost to be allocated	0	0	0	0	0	154	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.081611	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2014 To 04/30/2015

Worksheet H-2 Part II Date/Time Prepared: 9/28/2015 2:27 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	0	0			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	235	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
20.00	Total (sum of lines 1-19)	235	0			20.00
21.00	Total cost to be allocated	50	0			21.00
22.00	Unit cost multiplier	0.212766	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

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	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	507,374		507,374	2,578	196.81	1.00
2.00	Physical Therapy	3.00	425,233	0	425,233	3,597	118.22	2.00
3.00	Occupational Therapy	4.00	82,991	0	82,991	683	121.51	3.00
4.00	Speech Pathology	5.00	15,389	0	15,389	68	226.31	4.00
5.00	Medical Social Services	6.00	200		200	1	200.00	5.00
6.00	Home Health Aide	7.00	6,436		6,436	213	30.22	6.00
7.00	Total (sum of lines 1-6)		1,037,623	0	1,037,623	7,140		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	0	1,554			8.00
8.01	Skilled Nursing Care		99914	0	170			8.01
9.00	Physical Therapy		37900	0	1,842			9.00
9.01	Physical Therapy		99914	0	135			9.01
10.00	Occupational Therapy		37900	0	383			10.00
10.01	Occupational Therapy		99914	0	55			10.01
11.00	Speech Pathology		37900	0	78			11.00
11.01	Speech Pathology		99914	0	14			11.01
12.00	Medical Social Services		37900	0	0			12.00
12.01	Medical Social Services		99914	0	0			12.01
13.00	Home Health Aide		37900	0	165			13.00
13.01	Home Health Aide		99914	0	6			13.01
14.00	Total (sum of lines 8-13)			0	4,402			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	6,403	0	6,403	5,662	1.130872	15.00
16.00	Cost of Drugs	9.00	653	0	653	646	1.010836	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,724		0	339,300		1.00
2.00	Physical Therapy	0	1,977		0	233,721		2.00
3.00	Occupational Therapy	0	438		0	53,221		3.00
4.00	Speech Pathology	0	92		0	20,821		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	171		0	5,168		6.00
7.00	Total (sum of lines 1-6)	0	4,402		0	652,231		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 9/28/2015 2:27 pm

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

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	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	5,662	0				15.00
16.00	Cost of Drugs		196	0		198	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	339,300		1.00
2.00	Physical Therapy	233,721		2.00
3.00	Occupational Therapy	53,221		3.00
4.00	Speech Pathology	20,821		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	5,168		6.00
7.00	Total (sum of lines 1-6)	652,231		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-3 Part II | Date/Time Prepared: 9/28/2015 2:27 pm

HHA CCN: 147057 | 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	0.311053	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.341471	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.693468	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.417767	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.181250	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 9/28/2015 2:27 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	198	0	1.00
2.00	Total charges	0	196	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	196	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	2	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	198	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	704,011	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	10,336	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	12,073	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,454	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	479	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	464	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	735,015	22.00
23.00	Excess reasonable cost (from line 8)	0	2	23.00
24.00	Subtotal (line 22 minus line 23)	0	735,013	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	735,013	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	735,013	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	735,013	31.00
31.01	Sequestration adjustment (see instructions)	0	14,700	31.01
32.00	Interim payments (see instructions)	0	720,217	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	96	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: 140120 HHA CCN: 147057 | Period: From 05/01/2014 To 04/30/2015 | Worksheet H-5 | Date/Time Prepared: 9/28/2015 2:27 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		720,217	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		720,217	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		96	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		720,313	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140120	Period: From 05/01/2014 To 04/30/2015	Worksheet L Parts I-III Date/Time Prepared: 9/28/2015 2:27 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	742,369	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	21,399	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)	39.99	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)	2.41	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	17.12	8.00
9.00	Sum of lines 7 and 8	19.53	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.03	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	29,917	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	793,685	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