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: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/27/2016 3:50 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/27/2016 Time: 3:50 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 GALESBURG COTTAGE HOSPITAL (140040) for the cost reporting period beginning 05/01/2015 and ending 04/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	277,645	47,159	-18,287	0	1.00
2.00	Subprovider - IPF	0	30,059	439		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	1,868	0		0	7.00
200.00	Total	0	309,572	47,598	-18,287	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/27/2016 1:05 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 695 NORTH KELLOGG STREET	PO Box:			1.00
2.00	City: GALESBURG	State: IL	Zip Code: 61401	County: KNOX	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	GALESBURG COTTAGE HOSPITAL	140040	99914	1	07/06/1966	N	P	P	3.00
4.00	Subprovider - IPF	GALEBSURG COTTAGE PSYCH	14S040	99914	4	05/01/2006	N	P	N	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	GALESBURG COTTAGE SKILLED UNIT	145690	99914		01/11/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2015	04/30/2016	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	544	340	10	0	987	88	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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/27/2016 1:05 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	05/01/2015	04/30/2016	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	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 9/27/2016 1:05 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 9/27/2016 1:05 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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (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, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/27/2016 1:05 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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.					109.00

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			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:	50,976	831,042	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/27/2016 1:05 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BOULEVARD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/27/2016 1:05 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)	11/01/2014	01/29/2015	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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 9/27/2016 1:05 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)	Y			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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/16/2016	Y	08/16/2016
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	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 9/27/2016 1:05 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	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.	Y	12/31/2015	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.	N		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.	AMBER	WALKER	41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615 221-3646	AMBER_WALKER@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/27/2016 1:05 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 9/27/2016 1:05 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	84	30,744	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)		84	30,744	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,392	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)		96	35,136	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,392		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	34	12,444		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)		142				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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 9/27/2016 1:05 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)	3,443	290	6,526			1.00
2.00	HMO and other (see instructions)	1,481	1,006				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	66	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)	3,443	290	6,526			7.00
8.00	INTENSIVE CARE UNIT	897	18	1,497			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		567	802			13.00
14.00	Total (see instructions)	4,340	875	8,825	0.00	302.75	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,928	0	2,663	0.00	14.15	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,991	0	3,803	0.00	19.93	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	336.83	27.00
28.00	Observation Bed Days		0	856			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	88	142			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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 9/27/2016 1:05 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	947	486	2,230	1.00
2.00	HMO and other (see instructions)			264	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	947	486	2,230	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	105	0	152	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						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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 9/27/2016 1:05 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	18,250,199	0	18,250,199	700,605.00	26.05	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		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,039,438	0	1,039,438	41,444.00	25.08	9.00
10.00	Excluded area salaries (see instructions)		908,362	9,118	917,480	33,997.00	26.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,135,721	0	2,135,721	41,237.86	51.79	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		130,850	0	130,850	1,128.00	116.00	13.00
14.00	Home office salaries & wage-related costs		1,851,870	0	1,851,870	55,326.00	33.47	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		4,847,381	0	4,847,381			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		597,988	0	597,988			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	173,094	0	173,094	5,928.00	29.20	26.00
27.00	Administrative & General	5.00	2,267,225	-171,489	2,095,736	89,716.00	23.36	27.00
28.00	Administrative & General under contract (see inst.)		91,187	0	91,187	874.00	104.33	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	474,263	0	474,263	20,980.00	22.61	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	561,526	0	561,526	44,988.00	12.48	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		780,948	0	780,948	42,933.97	18.19	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,089,111	90,796	1,179,907	35,121.00	33.60	38.00
39.00	Central Services and Supply	14.00	82,611	0	82,611	6,295.00	13.12	39.00
40.00	Pharmacy	15.00	613,472	0	613,472	18,584.00	33.01	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 9/27/2016 1:05 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	438,200	0	438,200	21,931.00	19.98	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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 9/27/2016 1:05 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)		19,122,334	0	19,122,334	744,412.97	25.69	1.00
2.00	Excluded area salaries (see instructions)		1,947,800	9,118	1,956,918	75,441.00	25.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)		17,174,534	-9,118	17,165,416	668,971.97	25.66	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,118,441	0	4,118,441	97,691.86	42.16	4.00
5.00	Subtotal wage-related costs (see inst.)		4,847,381	0	4,847,381	0.00	28.24	5.00
6.00	Total (sum of lines 3 thru 5)		26,140,356	-9,118	26,131,238	766,663.83	34.08	6.00
7.00	Total overhead cost (see instructions)		6,571,637	-80,693	6,490,944	287,350.97	22.59	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 9/27/2016 1:05 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	291,310	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	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,213,915	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	11,984	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	16,015	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-184	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	15,185	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	401,183	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	1,037,948	17.00
18.00	Medicare Taxes - Employers Portion Only	242,746	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	135,592	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,365,694	24.00
	Part B - Other than Core Related Cost		
25.00	RELOCATION EXPENSES OTHER BENEFITS	79,674	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 9/27/2016 1:05 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			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			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	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-7 | Date/Time Prepared: 9/27/2016 1:05 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	4	0	4	5.00
6.00		RVL	11	0	11	6.00
7.00		RHX	3	0	3	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	16	0	16	9.00
10.00		RML	16	0	16	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	59	0	59	12.00
13.00		RUB	117	0	117	13.00
14.00		RUA	100	0	100	14.00
15.00		RVC	752	0	752	15.00
16.00		RVB	332	0	332	16.00
17.00		RVA	287	0	287	17.00
18.00		RHC	261	0	261	18.00
19.00		RHB	197	0	197	19.00
20.00		RHA	336	0	336	20.00
21.00		RMC	120	0	120	21.00
22.00		RMB	39	0	39	22.00
23.00		RMA	58	0	58	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	9	0	9	26.00
27.00		ES2	5	0	5	27.00
28.00		ES1	20	0	20	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	19	0	19	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	34	0	34	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	57	0	57	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	34	0	34	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	7	0	7	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	24	0	24	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	25	0	25	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	3	0	3	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	33	0	33	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	9	0	9	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-7 | Date/Time Prepared: 9/27/2016 1:05 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	4	0	4	199.00
200.00	TOTAL		2,991	0	2,991	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,064,482			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-10 | Date/Time Prepared: 9/27/2016 1:05 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)	0.137972	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,212,117	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	8,816,389	5.00
6.00	Medicaid charges	71,892,453	6.00
7.00	Medicaid cost (line 1 times line 6)	9,919,146	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	14,026	9.00
10.00	Stand-alone SCHIP charges	327,727	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	45,217	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	31,191	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)	31,191	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	25,951	82,157	108,108	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	3,581	11,335	14,916	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)	3,581	11,335	14,916	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)	1,775,894	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	399,135	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,376,759	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	189,954	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	204,870	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	236,061	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A | Date/Time Prepared: 9/27/2016 1:05 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		1,205,389	1,205,389	-207,320	998,069	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,800,590	2,800,590	517,077	3,317,667	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	173,094	151,358	324,452	3,956,100	4,280,552	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,267,225	11,294,794	13,562,019	-4,237,032	9,324,987	5.00
7.00	00700	OPERATION OF PLANT	474,263	1,419,369	1,893,632	800	1,894,432	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,909	178,909	0	178,909	8.00
9.00	00900	HOUSEKEEPING	561,526	258,901	820,427	0	820,427	9.00
10.00	01000	DIETARY	0	994,886	994,886	-697,644	297,242	10.00
11.00	01100	CAFETERIA	0	0	0	697,644	697,644	11.00
13.00	01300	NURSING ADMINISTRATION	1,089,111	192,143	1,281,254	91,450	1,372,704	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,611	2,525,169	2,607,780	-2,148,441	459,339	14.00
15.00	01500	PHARMACY	613,472	1,604,144	2,217,616	-1,453,805	763,811	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	438,200	301,200	739,400	-9,329	730,071	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,154,600	1,089,710	3,244,310	704,922	3,949,232	30.00
31.00	03100	INTENSIVE CARE UNIT	1,065,298	490,930	1,556,228	-1,592	1,554,636	31.00
40.00	04000	SUBPROVIDER - IPF	800,547	667,899	1,468,446	-1,770	1,466,676	40.00
43.00	04300	NURSERY	0	755	755	369,543	370,298	43.00
44.00	04400	SKILLED NURSING FACILITY	1,039,438	276,287	1,315,725	-2,075	1,313,650	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,067,055	944,890	2,011,945	414,980	2,426,925	50.00
51.00	05100	RECOVERY ROOM	375,922	39,944	415,866	-415,866	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	859,749	880,680	1,740,429	-1,081,569	658,860	52.00
53.00	05300	ANESTHESIOLOGY	1,007,384	548,511	1,555,895	0	1,555,895	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	682,803	883,542	1,566,345	760,658	2,327,003	54.00
54.01	05401	ULTRASOUND	97,062	29,808	126,870	-126,870	0	54.01
56.00	05600	RADIOISOTOPE	65,520	277,378	342,898	-342,898	0	56.00
57.00	05700	CT SCAN	126,494	170,701	297,195	-297,195	0	57.00
58.00	05800	MRI	89,485	128,439	217,924	-217,924	0	58.00
60.00	06000	LABORATORY	1,031,530	1,319,885	2,351,415	-60,348	2,291,067	60.00
65.00	06500	RESPIRATORY THERAPY	349,610	106,804	456,414	57,199	513,613	65.00
66.00	06600	PHYSICAL THERAPY	0	534,289	534,289	345,312	879,601	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	260,057	260,057	-260,057	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	85,255	85,255	-85,255	0	68.00
69.00	06900	ELECTROCARDIOLOGY	489,881	305,261	795,142	-972	794,170	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	545,247	545,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,560,453	1,560,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,358,790	1,358,790	73.00
74.00	07400	RENAL DIALYSIS	0	143,264	143,264	0	143,264	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	64,415	12,839	77,254	-77,254	0	76.01
76.03	03950	WOUND CARE	139,452	528,939	668,391	-1,623	666,768	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	936,637	1,370,503	2,307,140	1,270,962	3,578,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	71,575	1,203,584	1,275,159	-1,275,159	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,213,959	35,227,006	53,440,965	-350,861	53,090,104	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,794	71,683	101,477	0	101,477	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	350,861	350,861	194.01
194.02	07952	SENIOR CIRCLE	6,446	13,579	20,025	0	20,025	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	18,250,199	35,312,268	53,562,467	0	53,562,467	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A | Date/Time Prepared: 9/27/2016 1:05 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	1,527,964	2,526,033		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-328,057	2,989,610		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,855	4,272,697		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-591,607	8,733,380		5.00
7.00	00700	OPERATION OF PLANT	-14,074	1,880,358		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,909		8.00
9.00	00900	HOUSEKEEPING	0	820,427		9.00
10.00	01000	DIETARY	0	297,242		10.00
11.00	01100	CAFETERIA	0	697,644		11.00
13.00	01300	NURSING ADMINISTRATION	-5,343	1,367,361		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	459,339		14.00
15.00	01500	PHARMACY	0	763,811		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,445	728,626		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-670,203	3,279,029		30.00
31.00	03100	INTENSIVE CARE UNIT	-10,575	1,544,061		31.00
40.00	04000	SUBPROVIDER - IPF	-350,631	1,116,045		40.00
43.00	04300	NURSERY	0	370,298		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,313,650		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,426,925		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-305,122	353,738		52.00
53.00	05300	ANESTHESIOLOGY	-181,240	1,374,655		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,327,003		54.00
54.01	05401	ULTRASOUND	0	0		54.01
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
60.00	06000	LABORATORY	-90,000	2,201,067		60.00
65.00	06500	RESPIRATORY THERAPY	0	513,613		65.00
66.00	06600	PHYSICAL THERAPY	0	879,601		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	794,170		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	545,247		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,560,453		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,113	1,357,677		73.00
74.00	07400	RENAL DIALYSIS	0	143,264		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03950	WOUND CARE	0	666,768		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,934,571	1,643,531		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,963,872	50,126,232		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	101,477		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	350,861		194.01
194.02	07952	SENIOR CIRCLE	0	20,025		194.02
194.03	07953	UNUSED SPACE	0	0		194.03
194.04	07954	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-2,963,872	50,598,595		200.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-6 | Date/Time Prepared: 9/27/2016 1:05 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,958,402	1.00
	0		0	3,958,402	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	95,340	1.00
2.00	OPERATION OF PLANT	7.00	0	800	2.00
	0		0	96,140	
	C - RENTAL AND LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	511,772	1.00
2.00		0.00	0	0	2.00
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	511,772	
	D - OTHER CAP COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	95,558	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	202,015	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,305	3.00
	0		0	302,878	
	E - MARKETING DEPT				
1.00	MARKETING	194.01	80,693	270,168	1.00
	0		80,693	270,168	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	449,907	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,560,453	2.00
3.00	OPERATING ROOM	50.00	0	28,765	3.00
	0		0	2,039,125	
	G - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,358,790	1.00
	0		0	1,358,790	
	H - LABOR AND DELIV				
1.00	ADULTS & PEDIATRICS	30.00	424,291	286,447	1.00
2.00	NURSERY	43.00	220,970	148,573	2.00
	0		645,261	435,020	
	I - THERAPY COSTS				
1.00	PHYSICAL THERAPY	66.00	0	345,312	1.00
2.00		0.00	0	0	2.00
	0		0	345,312	
	J - MISCELLANEOUS DEPTS				
1.00	NURSING ADMINISTRATION	13.00	90,796	8,175	1.00
2.00	OPERATING ROOM	50.00	375,922	38,880	2.00
3.00	RESPIRATORY THERAPY	65.00	64,415	12,839	3.00
4.00	EMERGENCY	91.00	71,575	1,203,584	4.00
	0		602,708	1,263,478	
	K - OTHER RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	378,561	605,342	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
	0		378,561	605,342	
	L - DIETARY TO CAFETERIA				
1.00	CAFETERIA	11.00	0	697,644	1.00
	0		0	697,644	
500.00	Grand Total: Increases		1,707,223	11,884,071	500.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-6 | Date/Time Prepared: 9/27/2016 1:05 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,958,402	0		1.00
	0		0	3,958,402			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	96,140	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	96,140			
	C - RENTAL AND LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,302	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	30,813	10		2.00
4.00	NURSING ADMINISTRATION	13.00	0	7,521	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	13,176	0		5.00
6.00	PHARMACY	15.00	0	95,015	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,329	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	5,816	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	1,592	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	1,770	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	2,075	0		11.00
12.00	OPERATING ROOM	50.00	0	28,587	0		12.00
13.00	RECOVERY ROOM	51.00	0	1,064	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,288	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	223,245	0		15.00
16.00	MRI	58.00	0	984	0		16.00
17.00	LABORATORY	60.00	0	60,348	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	20,055	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	972	0		19.00
20.00	WOUND CARE	76.03	0	1,623	0		20.00
21.00	EMERGENCY	91.00	0	4,197	0		21.00
	0		0	511,772			
	D - OTHER CAP COSTS						
1.00		0.00	0	0	12		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	302,878	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	302,878			
	E - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	80,693	270,168	0		1.00
	0		80,693	270,168			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,039,125	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	2,039,125			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	1,358,790	0		1.00
	0		0	1,358,790			
	H - LABOR AND DELIV						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	645,261	435,020	0		1.00
2.00		0.00	0	0	0		2.00
	0		645,261	435,020			
	I - THERAPY COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	0	260,057	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	85,255	0		2.00
	0		0	345,312			
	J - MISCELLANEOUS DEPTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	90,796	8,175	0		1.00
2.00	RECOVERY ROOM	51.00	375,922	38,880	0		2.00
3.00	SLEEP LAB	76.01	64,415	12,839	0		3.00
4.00	AMBULANCE SERVICES	95.00	71,575	1,203,584	0		4.00
	0		602,708	1,263,478			
	K - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	97,062	29,808	0		1.00
2.00	RADIOISOTOPE	56.00	65,520	277,378	0		2.00
3.00	CT SCAN	57.00	126,494	170,701	0		3.00
4.00	MRI	58.00	89,485	127,455	0		4.00
	0		378,561	605,342			
	L - DIETARY TO CAFETERIA						
1.00	DIETARY	10.00	0	697,644	0		1.00
	0		0	697,644			
500.00	Grand Total: Decreases		1,707,223	11,884,071			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 9/27/2016 1:05 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	1,943,661	0	0	0	0	1.00
2.00	Land Improvements	1,017,583	6,900	0	6,900	0	2.00
3.00	Buildings and Fixtures	52,956,611	0	0	0	0	3.00
4.00	Building Improvements	9,286,454	804,921	0	804,921	0	4.00
5.00	Fixed Equipment	5,308,357	317,573	0	317,573	0	5.00
6.00	Movable Equipment	46,927,613	1,221,538	0	1,221,538	81,832	6.00
7.00	HIT designated Assets	4,746,758	3,187	0	3,187	0	7.00
8.00	Subtotal (sum of lines 1-7)	122,187,037	2,354,119	0	2,354,119	81,832	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	122,187,037	2,354,119	0	2,354,119	81,832	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,943,661	0	1.00
2.00	Land Improvements	1,024,483	0	2.00
3.00	Buildings and Fixtures	52,956,611	0	3.00
4.00	Building Improvements	10,091,375	0	4.00
5.00	Fixed Equipment	5,625,930	0	5.00
6.00	Movable Equipment	48,067,319	0	6.00
7.00	HIT designated Assets	4,749,945	0	7.00
8.00	Subtotal (sum of lines 1-7)	124,459,324	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	124,459,324	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 9/27/2016 1:05 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	1,205,389	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,800,590	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,005,979	0	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	0	1,205,389	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,800,590	2.00
3.00	Total (sum of lines 1-2)	0	4,005,979	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part III | Date/Time Prepared: 9/27/2016 1:05 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	66,016,130	0	66,016,130	0.530423	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,443,194	0	58,443,194	0.469577	0	2.00
3.00	Total (sum of lines 1-2)	124,459,324	0	124,459,324	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,671,347	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,339,310	511,772	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,010,657	511,772	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	828,049	95,558	-302,878	233,957	2,526,033	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,305	0	133,223	2,989,610	2.00
3.00	Total (sum of lines 1-2)	828,049	100,863	-302,878	367,180	5,515,643	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8 | Date/Time Prepared: 9/27/2016 1:05 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	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)	A	-50,860	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,712	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,547,685			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	4,072,826			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others	B	-14,383	CAP REL COSTS-BLDG & FIXT	1.00	14	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,113	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,445	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	B	-2,513	ADMINISTRATIVE & GENERAL	5.00	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	A	465,958	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-465,083	CAP REL COSTS-MVBLE EQUIP	2.00	9	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			0		0.00	0	33.00
36.00	OTHER MISCELLANEOUS REVENUE	B	-31,953	ADMINISTRATIVE & GENERAL	5.00	0	36.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8 | Date/Time Prepared: 9/27/2016 1:05 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	
37.00	DEPRECIATION - ADMIN AND GENERAL	A	-361,117	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00			0		0.00	0	38.00
40.00	PATIENT PHONES BENEFITS COST	A	-7,855	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	PATIENT PHONES DEPRECIATION COST	A	-15,312	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	PATIENT TV CABLE EXPENSE	A	-14,074	OPERATION OF PLANT	7.00	0	42.00
43.00	MARKETING EXP - EXCL MARKETING DEPT	A	-156,133	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	ILLINOIS PROVIDER TAX	A	-2,643,264	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	PHYSICIAN RECRUITING	A	-286,173	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-34,623	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	CHARITABLE CONTRIBUTIONS	A	-14,917	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00	PENALTIES	A	-78	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	CLUB DUES	A	-450	ADMINISTRATIVE & GENERAL	5.00	0	49.00
49.01	MINORITY INTEREST	A	208,241	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.02	NONALLOWABLE LEGAL FEES	A	-54,045	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.06	SPECIAL EVENTS	A	-1,109	ADMINISTRATIVE & GENERAL	5.00	0	49.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,963,872				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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 9/27/2016 1:05 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	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED INTEREST	828,049	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	OPERATING INTEREST	26,916	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	452,916	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	30,455	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BLDG AND FIXTU	9,644	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MVABLE EQUIPME	133,223	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HO COSTS	1,603,595	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-3,393,230	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1,924,521	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	PASI FEES	0	253,032	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	4,125	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	882,018	615,878	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	307,258	286,210	4.09
4.10	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	4,779	0	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	24,995	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	891,358	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	QHC SPECIFIC COSTS & OFFSET	420,247	0	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICE CENTER ALLOCA	179,846	0	4.14
4.17	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	49,592	4.17
4.20	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	105,983	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	43,656	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,878,946	806,120	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		0.00	CHSPSC, LLC	100.00	6.00
7.00	B		0.00	PASI	100.00	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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 9/27/2016 1:05 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	828,049	11		1.00
2.00	26,916	0		2.00
3.00	452,916	0		3.00
4.00	30,455	14		4.00
4.01	9,644	14		4.01
4.02	133,223	14		4.02
4.03	1,603,595	0		4.03
4.04	3,393,230	0		4.04
4.05	-1,924,521	0		4.05
4.06	-253,032	0		4.06
4.07	-4,125	0		4.07
4.08	266,140	0		4.08
4.09	21,048	9		4.09
4.10	4,779	9		4.10
4.11	-24,995	0		4.11
4.12	-891,358	0		4.12
4.13	420,247	0		4.13
4.14	179,846	0		4.14
4.17	-49,592	0		4.17
4.20	-105,983	0		4.20
4.21	-43,656	0		4.21
5.00	4,072,826			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	HOSPITAL COMPAN		6.00
7.00	COLLECTION AGEN		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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 9/27/2016 1:05 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	13.00	NURSING ADMINISTRATION	21,000	0	21,000	171,400	190	1.00
2.00	30.00	ADULTS & PEDIATRICS	670,203	670,203	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	10,575	10,575	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	350,631	350,631	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	305,122	305,122	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	181,240	181,240	0	0	0	6.00
7.00	60.00	LABORATORY	90,000	90,000	0	0	0	7.00
8.00	91.00	EMERGENCY	1,934,571	1,934,571	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			3,563,342	3,542,342	21,000		190	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	13.00	NURSING ADMINISTRATION	15,657	783	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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			15,657	783	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	13.00	NURSING ADMINISTRATION	0	15,657	5,343	5,343		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	670,203		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	10,575		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	350,631		4.00
5.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	305,122		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	181,240		6.00
7.00	60.00	LABORATORY	0	0	0	90,000		7.00
8.00	91.00	EMERGENCY	0	0	0	1,934,571		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	15,657	5,343	3,547,685		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/27/2016 1:05 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	2,526,033	2,526,033				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,989,610		2,989,610			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,272,697	8,857	10,513	4,292,067		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,733,380	330,771	392,610	497,593	9,954,354	5.00
7.00	00700	OPERATION OF PLANT	1,880,358	751,609	892,125	112,605	3,636,697	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	178,909	18,749	22,254	0	219,912	8.00
9.00	00900	HOUSEKEEPING	820,427	26,937	31,973	133,324	1,012,661	9.00
10.00	01000	DIETARY	297,242	68,513	81,322	0	447,077	10.00
11.00	01100	CAFETERIA	697,644	33,381	39,621	0	770,646	11.00
13.00	01300	NURSING ADMINISTRATION	1,367,361	37,220	44,178	280,146	1,728,905	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	459,339	76,239	90,493	19,614	645,685	14.00
15.00	01500	PHARMACY	763,811	27,025	32,077	145,657	968,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	728,626	75,044	89,074	104,042	996,786	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,279,029	279,605	331,878	612,312	4,502,824	30.00
31.00	03100	INTENSIVE CARE UNIT	1,544,061	42,715	50,701	252,935	1,890,412	31.00
40.00	04000	SUBPROVIDER - IPF	1,116,045	58,366	69,278	190,075	1,433,764	40.00
43.00	04300	NURSERY	370,298	11,135	13,217	52,465	447,115	43.00
44.00	04400	SKILLED NURSING FACILITY	1,313,650	115,800	137,450	246,795	1,813,695	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,426,925	145,334	163,826	342,607	3,078,692	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	353,738	0	0	50,926	404,664	52.00
53.00	05300	ANESTHESIOLOGY	1,374,655	3,409	4,046	239,184	1,621,294	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,327,003	106,808	126,777	252,001	2,812,589	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	2,201,067	58,470	69,401	244,917	2,573,855	60.00
65.00	06500	RESPIRATORY THERAPY	513,613	21,951	26,055	98,302	659,921	65.00
66.00	06600	PHYSICAL THERAPY	879,601	11,899	14,124	0	905,624	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	794,170	68,784	81,644	116,313	1,060,911	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	545,247	0	0	0	545,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,560,453	0	0	0	1,560,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,357,677	0	0	0	1,357,677	73.00
74.00	07400	RENAL DIALYSIS	143,264	0	0	0	143,264	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	666,768	44,794	53,169	33,110	797,841	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,643,531	49,565	58,831	239,381	1,991,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,126,232	2,472,980	2,926,637	4,264,304	49,982,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	101,477	23,297	27,653	7,074	159,501	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,399	8,783	0	16,182	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	350,861	0	0	19,159	370,020	194.01
194.02	07952	SENIOR CIRCLE	20,025	0	0	1,530	21,555	194.02
194.03	07953	UNUSED SPACE	0	22,357	26,537	0	48,894	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	50,598,595	2,526,033	2,989,610	4,292,067	50,598,595	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I Date/Time Prepared: 9/27/2016 1:05 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	9,954,354					5.00
7.00	00700	OPERATION OF PLANT	890,678	4,527,375				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	53,860	59,161	332,933			8.00
9.00	00900	HOUSEKEEPING	248,015	84,997	0	1,345,673		9.00
10.00	01000	DIETARY	109,495	216,188	0	66,371	839,131	10.00
11.00	01100	CAFETERIA	188,742	105,329	0	32,337	0	11.00
13.00	01300	NURSING ADMINISTRATION	423,433	117,443	0	36,056	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	158,137	240,566	4,233	73,855	0	14.00
15.00	01500	PHARMACY	237,216	85,274	0	26,180	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	244,127	236,796	0	72,698	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,102,816	882,267	101,744	270,861	304,718	30.00
31.00	03100	INTENSIVE CARE UNIT	462,988	134,784	30,997	41,380	82,874	31.00
40.00	04000	SUBPROVIDER - IPF	351,149	184,169	20,365	56,541	135,606	40.00
43.00	04300	NURSERY	109,505	35,135	0	10,787	0	43.00
44.00	04400	SKILLED NURSING FACILITY	444,199	365,398	34,631	112,179	195,874	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	754,015	458,588	33,451	140,789	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,108	0	0	0	45,196	52.00
53.00	05300	ANESTHESIOLOGY	397,078	10,757	5	3,302	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	688,842	337,024	22,991	103,468	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	630,373	184,496	2,177	56,641	0	60.00
65.00	06500	RESPIRATORY THERAPY	161,624	69,265	1,338	21,265	0	65.00
66.00	06600	PHYSICAL THERAPY	221,800	37,548	0	11,527	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	259,832	217,042	5,214	66,633	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	133,539	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	382,177	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	332,514	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	35,087	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	195,402	141,344	8,419	43,393	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	487,699	156,398	49,228	48,015	9,367	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,803,450	4,359,969	314,793	1,294,278	773,635	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,064	73,512	0	22,569	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,963	23,348	18,140	7,168	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	90,623	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	5,279	0	0	0	8,222	194.02
194.03	07953	UNUSED SPACE	11,975	70,546	0	21,658	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	57,274	194.04
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)	9,954,354	4,527,375	332,933	1,345,673	839,131	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/27/2016 1:05 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	1,097,054					11.00
13.00	01300	NURSING ADMINISTRATION	71,503	2,377,340				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,827	0	1,135,303			14.00
15.00	01500	PHARMACY	37,805	0	3,560	1,358,605		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,620	0	2,354	0	1,597,381	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	216,965	653,741	54,097	0	103,793	30.00
31.00	03100	INTENSIVE CARE UNIT	76,456	270,049	28,977	0	40,411	31.00
40.00	04000	SUBPROVIDER - IPF	59,903	202,935	6,530	0	40,645	40.00
43.00	04300	NURSERY	13,674	56,015	216	0	7,792	43.00
44.00	04400	SKILLED NURSING FACILITY	84,372	263,493	27,723	0	13,640	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	101,857	365,789	171,614	0	327,441	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,912	54,372	29,523	0	7,329	52.00
53.00	05300	ANESTHESIOLOGY	27,475	255,368	19,976	0	111,068	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	77,768	0	27,205	0	231,651	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	100,798	0	120,340	0	275,745	60.00
65.00	06500	RESPIRATORY THERAPY	34,545	0	13,538	0	36,313	65.00
66.00	06600	PHYSICAL THERAPY	0	0	525	0	26,816	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	34,587	0	1,897	0	66,392	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	128,490	0	29,111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	445,652	0	64,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,358,605	39,433	73.00
74.00	07400	RENAL DIALYSIS	0	0	78	0	3,389	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	11,981	0	11,740	0	22,640	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	67,693	255,578	41,026	0	149,277	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,087,741	2,377,340	1,135,061	1,358,605	1,597,381	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,064	0	41	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,233	0	201	0	0	194.01
194.02	07952	SENIOR CIRCLE	1,016	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	1,097,054	2,377,340	1,135,303	1,358,605	1,597,381	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/27/2016 1:05 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	8,193,826	0	8,193,826		30.00
31.00	03100	INTENSIVE CARE UNIT	3,059,328	0	3,059,328		31.00
40.00	04000	SUBPROVIDER - IPF	2,491,607	0	2,491,607		40.00
43.00	04300	NURSERY	680,239	0	680,239		43.00
44.00	04400	SKILLED NURSING FACILITY	3,355,204	0	3,355,204		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,432,236	0	5,432,236		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653,104	0	653,104		52.00
53.00	05300	ANESTHESIOLOGY	2,446,323	0	2,446,323		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,301,538	0	4,301,538		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	3,944,425	0	3,944,425		60.00
65.00	06500	RESPIRATORY THERAPY	997,809	0	997,809		65.00
66.00	06600	PHYSICAL THERAPY	1,203,840	0	1,203,840		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	1,712,508	0	1,712,508		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	836,387	0	836,387		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,452,777	0	2,452,777		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,088,229	0	3,088,229		73.00
74.00	07400	RENAL DIALYSIS	181,818	0	181,818		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03950	WOUND CARE	1,232,760	0	1,232,760		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,255,589	0	3,255,589		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,519,547	0	49,519,547		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	298,751	0	298,751		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	68,801	0	68,801		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	465,077	0	465,077		194.01
194.02	07952	SENIOR CIRCLE	36,072	0	36,072		194.02
194.03	07953	UNUSED SPACE	153,073	0	153,073		194.03
194.04	07954	GUEST MEALS	57,274	0	57,274		194.04
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)	50,598,595	0	50,598,595		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/27/2016 1:05 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	8,857	10,513	19,370	19,370	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	330,771	392,610	723,381	2,247	5.00
7.00	00700	OPERATION OF PLANT	0	751,609	892,125	1,643,734	508	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,749	22,254	41,003	0	8.00
9.00	00900	HOUSEKEEPING	0	26,937	31,973	58,910	602	9.00
10.00	01000	DIETARY	0	68,513	81,322	149,835	0	10.00
11.00	01100	CAFETERIA	0	33,381	39,621	73,002	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	37,220	44,178	81,398	1,265	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	76,239	90,493	166,732	89	14.00
15.00	01500	PHARMACY	0	27,025	32,077	59,102	658	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,044	89,074	164,118	470	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	279,605	331,878	611,483	2,754	30.00
31.00	03100	INTENSIVE CARE UNIT	0	42,715	50,701	93,416	1,142	31.00
40.00	04000	SUBPROVIDER - IPF	0	58,366	69,278	127,644	858	40.00
43.00	04300	NURSERY	0	11,135	13,217	24,352	237	43.00
44.00	04400	SKILLED NURSING FACILITY	0	115,800	137,450	253,250	1,114	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	145,334	163,826	309,160	1,547	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	230	52.00
53.00	05300	ANESTHESIOLOGY	0	3,409	4,046	7,455	1,080	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	106,808	126,777	233,585	1,138	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	58,470	69,401	127,871	1,106	60.00
65.00	06500	RESPIRATORY THERAPY	0	21,951	26,055	48,006	444	65.00
66.00	06600	PHYSICAL THERAPY	0	11,899	14,124	26,023	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	68,784	81,644	150,428	525	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	44,794	53,169	97,963	149	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	49,565	58,831	108,396	1,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,472,980	2,926,637	5,399,617	19,244	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,297	27,653	50,950	32	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,399	8,783	16,182	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	87	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	7	194.02
194.03	07953	UNUSED SPACE	0	22,357	26,537	48,894	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	2,526,033	2,989,610	5,515,643	19,370	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/27/2016 1:05 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	725,628					5.00
7.00	00700	OPERATION OF PLANT	64,926	1,709,168				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,926	22,335	67,264			8.00
9.00	00900	HOUSEKEEPING	18,079	32,088	0	109,679		9.00
10.00	01000	DIETARY	7,982	81,615	0	5,410	244,842	10.00
11.00	01100	CAFETERIA	13,758	39,764	0	2,636	0	11.00
13.00	01300	NURSING ADMINISTRATION	30,866	44,337	0	2,939	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,527	90,818	855	6,020	0	14.00
15.00	01500	PHARMACY	17,292	32,192	0	2,134	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,796	89,395	0	5,925	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,394	333,071	20,557	22,076	88,911	30.00
31.00	03100	INTENSIVE CARE UNIT	33,750	50,884	6,262	3,373	24,181	31.00
40.00	04000	SUBPROVIDER - IPF	25,597	69,527	4,114	4,608	39,567	40.00
43.00	04300	NURSERY	7,982	13,264	0	879	0	43.00
44.00	04400	SKILLED NURSING FACILITY	32,380	137,944	6,997	9,143	57,152	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,964	173,126	6,758	11,475	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,224	0	0	0	13,187	52.00
53.00	05300	ANESTHESIOLOGY	28,945	4,061	1	269	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,213	127,233	4,645	8,433	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	45,951	69,651	440	4,617	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,782	26,149	270	1,733	0	65.00
66.00	06600	PHYSICAL THERAPY	16,168	14,175	0	940	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	18,940	81,937	1,053	5,431	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,734	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,859	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,239	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,558	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	14,244	53,360	1,701	3,537	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	35,551	59,043	9,946	3,913	2,733	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	714,627	1,645,969	63,599	105,491	225,731	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,848	27,752	0	1,839	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	289	8,814	3,665	584	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	6,606	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	385	0	0	0	2,399	194.02
194.03	07953	UNUSED SPACE	873	26,633	0	1,765	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	16,712	194.04
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)	725,628	1,709,168	67,264	109,679	244,842	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/27/2016 1:05 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	129,160					11.00
13.00	01300	NURSING ADMINISTRATION	8,418	169,223				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,510	0	277,551			14.00
15.00	01500	PHARMACY	4,451	0	870	116,699		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,253	0	575	0	283,532	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,545	46,537	13,225	0	18,422	30.00
31.00	03100	INTENSIVE CARE UNIT	9,001	19,222	7,084	0	7,173	31.00
40.00	04000	SUBPROVIDER - IPF	7,053	14,445	1,596	0	7,214	40.00
43.00	04300	NURSERY	1,610	3,987	53	0	1,383	43.00
44.00	04400	SKILLED NURSING FACILITY	9,933	18,756	6,778	0	2,421	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,992	26,037	41,955	0	58,132	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,520	3,870	7,218	0	1,301	52.00
53.00	05300	ANESTHESIOLOGY	3,235	18,177	4,884	0	19,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,156	0	6,651	0	41,115	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	11,867	0	29,420	0	48,941	60.00
65.00	06500	RESPIRATORY THERAPY	4,067	0	3,310	0	6,445	65.00
66.00	06600	PHYSICAL THERAPY	0	0	128	0	4,760	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	4,072	0	464	0	11,784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	31,413	0	5,167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	108,949	0	11,447	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	116,699	6,999	73.00
74.00	07400	RENAL DIALYSIS	0	0	19	0	602	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	1,411	0	2,870	0	4,018	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	7,970	18,192	10,030	0	26,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,064	169,223	277,492	116,699	283,532	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	478	0	10	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	498	0	49	0	0	194.01
194.02	07952	SENIOR CIRCLE	120	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	129,160	169,223	277,551	116,699	283,532	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/27/2016 1:05 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	1,262,975	0	1,262,975		30.00
31.00	03100	INTENSIVE CARE UNIT	255,488	0	255,488		31.00
40.00	04000	SUBPROVIDER - IPF	302,223	0	302,223		40.00
43.00	04300	NURSERY	53,747	0	53,747		43.00
44.00	04400	SKILLED NURSING FACILITY	535,868	0	535,868		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	695,146	0	695,146		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,550	0	34,550		52.00
53.00	05300	ANESTHESIOLOGY	87,820	0	87,820		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	482,169	0	482,169		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	339,864	0	339,864		60.00
65.00	06500	RESPIRATORY THERAPY	102,206	0	102,206		65.00
66.00	06600	PHYSICAL THERAPY	62,194	0	62,194		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	274,634	0	274,634		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,314	0	46,314		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,255	0	148,255		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	147,937	0	147,937		73.00
74.00	07400	RENAL DIALYSIS	3,179	0	3,179		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03950	WOUND CARE	179,253	0	179,253		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	283,350	0	283,350		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,297,172	0	5,297,172		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	83,909	0	83,909		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,534	0	29,534		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	7,240	0	7,240		194.01
194.02	07952	SENIOR CIRCLE	2,911	0	2,911		194.02
194.03	07953	UNUSED SPACE	78,165	0	78,165		194.03
194.04	07954	GUEST MEALS	16,712	0	16,712		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	5,515,643	0	5,515,643		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/27/2016 1:05 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	317,149					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		316,231				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,112	1,112	18,077,105			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,529	41,529	2,095,736	-9,954,354	40,644,241	5.00
7.00	00700	OPERATION OF PLANT	94,366	94,366	474,263	0	3,636,697	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	2,354	0	0	219,912	8.00
9.00	00900	HOUSEKEEPING	3,382	3,382	561,526	0	1,012,661	9.00
10.00	01000	DIETARY	8,602	8,602	0	0	447,077	10.00
11.00	01100	CAFETERIA	4,191	4,191	0	0	770,646	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	4,673	1,179,907	0	1,728,905	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,572	9,572	82,611	0	645,685	14.00
15.00	01500	PHARMACY	3,393	3,393	613,472	0	968,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	9,422	438,200	0	996,786	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,105	35,105	2,578,891	0	4,502,824	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	5,363	1,065,298	0	1,890,412	31.00
40.00	04000	SUBPROVIDER - IPF	7,328	7,328	800,547	0	1,433,764	40.00
43.00	04300	NURSERY	1,398	1,398	220,970	0	447,115	43.00
44.00	04400	SKILLED NURSING FACILITY	14,539	14,539	1,039,438	0	1,813,695	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,247	17,329	1,442,977	0	3,078,692	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	214,488	0	404,664	52.00
53.00	05300	ANESTHESIOLOGY	428	428	1,007,384	0	1,621,294	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,410	13,410	1,061,364	0	2,812,589	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	7,341	7,341	1,031,530	0	2,573,855	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	2,756	414,025	0	659,921	65.00
66.00	06600	PHYSICAL THERAPY	1,494	1,494	0	0	905,624	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	8,636	8,636	489,881	0	1,060,911	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	545,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,560,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,357,677	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	143,264	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,624	5,624	139,452	0	797,841	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,223	6,223	1,008,212	0	1,991,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,488	309,570	17,960,172	-9,954,354	40,028,089	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	2,925	29,794	0	159,501	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	929	0	0	16,182	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	80,693	0	370,020	194.01
194.02	07952	SENIOR CIRCLE	0	0	6,446	0	21,555	194.02
194.03	07953	UNUSED SPACE	2,807	2,807	0	0	48,894	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	2,526,033	2,989,610	4,292,067		9,954,354	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.964815	9.453880	0.237431		0.244914	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			19,370		725,628	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001072		0.017853	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/27/2016 1:05 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			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	180,142					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	429,223				8.00
9.00	00900	HOUSEKEEPING	3,382	0	174,406			9.00
10.00	01000	DIETARY	8,602	0	8,602	47,660		10.00
11.00	01100	CAFETERIA	4,191	0	4,191	0	25,914	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	0	4,673	0	1,689	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,572	5,457	9,572	0	303	14.00
15.00	01500	PHARMACY	3,393	0	3,393	0	893	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	0	9,422	0	1,054	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,105	131,172	35,105	17,307	5,125	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	39,962	5,363	4,707	1,806	31.00
40.00	04000	SUBPROVIDER - IPF	7,328	26,255	7,328	7,702	1,415	40.00
43.00	04300	NURSERY	1,398	0	1,398	0	323	43.00
44.00	04400	SKILLED NURSING FACILITY	14,539	44,647	14,539	11,125	1,993	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,247	43,126	18,247	0	2,406	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,567	305	52.00
53.00	05300	ANESTHESIOLOGY	428	6	428	0	649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,410	29,640	13,410	0	1,837	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	7,341	2,806	7,341	0	2,381	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	1,725	2,756	0	816	65.00
66.00	06600	PHYSICAL THERAPY	1,494	0	1,494	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	8,636	6,722	8,636	0	817	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	5,624	10,854	5,624	0	283	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,223	63,465	6,223	532	1,599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	173,481	405,837	167,745	43,940	25,694	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	0	2,925	0	96	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	23,386	929	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	100	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	467	24	194.02
194.03	07953	UNUSED SPACE	2,807	0	2,807	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	3,253	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,527,375	332,933	1,345,673	839,131	1,097,054	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.132257	0.775664	7.715749	17.606609	42.334414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,709,168	67,264	109,679	244,842	129,160	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.487893	0.156711	0.628872	5.137264	4.984178	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/27/2016 1:05 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			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	9,378,204					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,975,260				14.00
15.00	01500	PHARMACY	0	12,466	1,358,790			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,241	0	358,909,300		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,578,891	189,422	0	23,319,131		30.00
31.00	03100	INTENSIVE CARE UNIT	1,065,298	101,464	0	9,079,142		31.00
40.00	04000	SUBPROVIDER - IPF	800,547	22,865	0	9,131,613		40.00
43.00	04300	NURSERY	220,970	755	0	1,750,666		43.00
44.00	04400	SKILLED NURSING FACILITY	1,039,438	97,073	0	3,064,482		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,442,977	600,905	0	73,592,931		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	214,487	103,376	0	1,646,680		52.00
53.00	05300	ANESTHESIOLOGY	1,007,384	69,947	0	24,953,446		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	95,257	0	52,044,735		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	421,369	0	61,951,223		60.00
65.00	06500	RESPIRATORY THERAPY	0	47,402	0	8,158,434		65.00
66.00	06600	PHYSICAL THERAPY	0	1,838	0	6,024,688		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	6,644	0	14,916,300		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	449,907	0	6,540,413		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,560,453	0	14,490,091		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,358,790	8,859,341		73.00
74.00	07400	RENAL DIALYSIS	0	273	0	761,502		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03950	WOUND CARE	0	41,107	0	5,086,591		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,008,212	143,651	0	33,537,891		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,378,204	3,974,415	1,358,790	358,909,300		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	142	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	703	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0		194.02
194.03	07953	UNUSED SPACE	0	0	0	0		194.03
194.04	07954	GUEST MEALS	0	0	0	0		194.04
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)	2,377,340	1,135,303	1,358,605	1,597,381		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.253496	0.285592	0.999864	0.004451		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	169,223	277,551	116,699	283,532		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.018044	0.069820	0.085885	0.000790		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,193,826		8,193,826	0	8,193,826	30.00
31.00	03100	INTENSIVE CARE UNIT	3,059,328		3,059,328	0	3,059,328	31.00
40.00	04000	SUBPROVIDER - IPF	2,491,607		2,491,607	0	2,491,607	40.00
43.00	04300	NURSERY	680,239		680,239	0	680,239	43.00
44.00	04400	SKILLED NURSING FACILITY	3,355,204		3,355,204	0	3,355,204	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,432,236		5,432,236	0	5,432,236	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653,104		653,104	0	653,104	52.00
53.00	05300	ANESTHESIOLOGY	2,446,323		2,446,323	0	2,446,323	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,301,538		4,301,538	0	4,301,538	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,944,425		3,944,425	0	3,944,425	60.00
65.00	06500	RESPIRATORY THERAPY	997,809	0	997,809	0	997,809	65.00
66.00	06600	PHYSICAL THERAPY	1,203,840	0	1,203,840	0	1,203,840	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	1,712,508		1,712,508	0	1,712,508	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	836,387		836,387	0	836,387	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,452,777		2,452,777	0	2,452,777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,088,229		3,088,229	0	3,088,229	73.00
74.00	07400	RENAL DIALYSIS	181,818		181,818	0	181,818	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03950	WOUND CARE	1,232,760		1,232,760	0	1,232,760	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,255,589		3,255,589	0	3,255,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	950,134		950,134		950,134	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	50,469,681	0	50,469,681	0	50,469,681	200.00
201.00		Less Observation Beds	950,134		950,134		950,134	201.00
202.00		Total (see instructions)	49,519,547	0	49,519,547	0	49,519,547	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,594,889		19,594,889			30.00
31.00	03100	INTENSIVE CARE UNIT	9,079,142		9,079,142			31.00
40.00	04000	SUBPROVIDER - IPF	9,131,613		9,131,613			40.00
43.00	04300	NURSERY	1,750,666		1,750,666			43.00
44.00	04400	SKILLED NURSING FACILITY	3,064,482		3,064,482			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,513,356	47,079,575	73,592,931	0.073815	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,450,310	196,370	1,646,680	0.396619	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,468,214	15,485,232	24,953,446	0.098035	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,788,455	44,256,280	52,044,735	0.082651	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	15,950,318	46,000,905	61,951,223	0.063670	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,780,695	2,377,739	8,158,434	0.122304	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,816,734	207,954	6,024,688	0.199818	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,644,637	11,271,663	14,916,300	0.114808	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,945,502	1,594,911	6,540,413	0.127880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,724,850	4,765,241	14,490,091	0.169273	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,099,207	3,760,134	8,859,341	0.348585	0.000000	73.00
74.00	07400	RENAL DIALYSIS	732,307	29,195	761,502	0.238762	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03950	WOUND CARE	11,496	5,075,095	5,086,591	0.242355	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,767,609	28,770,282	33,537,891	0.097072	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	754,100	2,970,142	3,724,242	0.255121	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	145,068,582	213,840,718	358,909,300			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	145,068,582	213,840,718	358,909,300			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio 11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.073815	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.396619	52.00
53.00	05300	ANESTHESIOLOGY	0.098035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082651	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.063670	60.00
65.00	06500	RESPIRATORY THERAPY	0.122304	65.00
66.00	06600	PHYSICAL THERAPY	0.199818	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114808	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.127880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.169273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348585	73.00
74.00	07400	RENAL DIALYSIS	0.238762	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03950	WOUND CARE	0.242355	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.097072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255121	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,193,826		8,193,826	0	8,193,826	30.00
31.00	03100	INTENSIVE CARE UNIT	3,059,328		3,059,328	0	3,059,328	31.00
40.00	04000	SUBPROVIDER - IPF	2,491,607		2,491,607	0	2,491,607	40.00
43.00	04300	NURSERY	680,239		680,239	0	680,239	43.00
44.00	04400	SKILLED NURSING FACILITY	3,355,204		3,355,204	0	3,355,204	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,432,236		5,432,236	0	5,432,236	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653,104		653,104	0	653,104	52.00
53.00	05300	ANESTHESIOLOGY	2,446,323		2,446,323	0	2,446,323	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,301,538		4,301,538	0	4,301,538	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	3,944,425		3,944,425	0	3,944,425	60.00
65.00	06500	RESPIRATORY THERAPY	997,809	0	997,809	0	997,809	65.00
66.00	06600	PHYSICAL THERAPY	1,203,840	0	1,203,840	0	1,203,840	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	1,712,508		1,712,508	0	1,712,508	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	836,387		836,387	0	836,387	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,452,777		2,452,777	0	2,452,777	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,088,229		3,088,229	0	3,088,229	73.00
74.00	07400	RENAL DIALYSIS	181,818		181,818	0	181,818	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03950	WOUND CARE	1,232,760		1,232,760	0	1,232,760	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,255,589		3,255,589	0	3,255,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	950,134		950,134		950,134	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	50,469,681	0	50,469,681	0	50,469,681	200.00
201.00		Less Observation Beds	950,134		950,134		950,134	201.00
202.00		Total (see instructions)	49,519,547	0	49,519,547	0	49,519,547	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,594,889		19,594,889			30.00
31.00	03100	INTENSIVE CARE UNIT	9,079,142		9,079,142			31.00
40.00	04000	SUBPROVIDER - IPF	9,131,613		9,131,613			40.00
43.00	04300	NURSERY	1,750,666		1,750,666			43.00
44.00	04400	SKILLED NURSING FACILITY	3,064,482		3,064,482			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,513,356	47,079,575	73,592,931	0.073815	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,450,310	196,370	1,646,680	0.396619	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,468,214	15,485,232	24,953,446	0.098035	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,788,455	44,256,280	52,044,735	0.082651	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	15,950,318	46,000,905	61,951,223	0.063670	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,780,695	2,377,739	8,158,434	0.122304	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,816,734	207,954	6,024,688	0.199818	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,644,637	11,271,663	14,916,300	0.114808	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,945,502	1,594,911	6,540,413	0.127880	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,724,850	4,765,241	14,490,091	0.169273	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,099,207	3,760,134	8,859,341	0.348585	0.000000	73.00
74.00	07400	RENAL DIALYSIS	732,307	29,195	761,502	0.238762	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03950	WOUND CARE	11,496	5,075,095	5,086,591	0.242355	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,767,609	28,770,282	33,537,891	0.097072	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	754,100	2,970,142	3,724,242	0.255121	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	145,068,582	213,840,718	358,909,300			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	145,068,582	213,840,718	358,909,300			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.073815	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.396619	52.00
53.00	05300	ANESTHESIOLOGY	0.098035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082651	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.063670	60.00
65.00	06500	RESPIRATORY THERAPY	0.122304	65.00
66.00	06600	PHYSICAL THERAPY	0.199818	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114808	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.127880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.169273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348585	73.00
74.00	07400	RENAL DIALYSIS	0.238762	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.03	03950	WOUND CARE	0.242355	76.03
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.097072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255121	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part II Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,432,236	695,146	4,737,090	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653,104	34,550	618,554	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,446,323	87,820	2,358,503	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,301,538	482,169	3,819,369	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	3,944,425	339,864	3,604,561	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	997,809	102,206	895,603	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,203,840	62,194	1,141,646	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	1,712,508	274,634	1,437,874	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	836,387	46,314	790,073	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,452,777	148,255	2,304,522	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,088,229	147,937	2,940,292	0	0	73.00
74.00	07400	RENAL DIALYSIS	181,818	3,179	178,639	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	1,232,760	179,253	1,053,507	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,255,589	283,350	2,972,239	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	950,134	146,451	803,683	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	32,689,477	3,033,322	29,656,155	0	0	200.00
201.00		Less Observation Beds	950,134	146,451	803,683	0	0	201.00
202.00		Total (line 200 minus line 201)	31,739,343	2,886,871	28,852,472	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part II Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,432,236	73,592,931	0.073815		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	653,104	1,646,680	0.396619		52.00
53.00	05300	ANESTHESIOLOGY	2,446,323	24,953,446	0.098035		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,301,538	52,044,735	0.082651		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	3,944,425	61,951,223	0.063670		60.00
65.00	06500	RESPIRATORY THERAPY	997,809	8,158,434	0.122304		65.00
66.00	06600	PHYSICAL THERAPY	1,203,840	6,024,688	0.199818		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,712,508	14,916,300	0.114808		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	836,387	6,540,413	0.127880		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,452,777	14,490,091	0.169273		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,088,229	8,859,341	0.348585		73.00
74.00	07400	RENAL DIALYSIS	181,818	761,502	0.238762		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	0	0	0.000000		76.01
76.03	03950	WOUND CARE	1,232,760	5,086,591	0.242355		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,255,589	33,537,891	0.097072		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	950,134	3,724,242	0.255121		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
200.00		Subtotal (sum of lines 50 thru 199)	32,689,477	316,288,508			200.00
201.00		Less Observation Beds	950,134	0			201.00
202.00		Total (line 200 minus line 201)	31,739,343	316,288,508			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part I Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,262,975	0	1,262,975	7,382	171.09	30.00
31.00	INTENSIVE CARE UNIT	255,488		255,488	1,497	170.67	31.00
40.00	SUBPROVIDER - IPF	302,223	0	302,223	2,663	113.49	40.00
43.00	NURSERY	53,747		53,747	802	67.02	43.00
44.00	SKILLED NURSING FACILITY	535,868		535,868	3,803	140.91	44.00
200.00	Total (lines 30-199)	2,410,301		2,410,301	16,147		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	3,443	589,063		30.00
31.00	INTENSIVE CARE UNIT	897	153,091		31.00
40.00	SUBPROVIDER - IPF	1,928	218,809		40.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	2,991	421,462		44.00
200.00	Total (lines 30-199)	9,259	1,382,425		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part II Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	695,146	73,592,931	0.009446	12,343,586	116,598	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,550	1,646,680	0.020982	0	0	52.00
53.00	05300	ANESTHESIOLOGY	87,820	24,953,446	0.003519	4,328,620	15,232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	482,169	52,044,735	0.009265	4,621,068	42,814	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	339,864	61,951,223	0.005486	7,346,816	40,305	60.00
65.00	06500	RESPIRATORY THERAPY	102,206	8,158,434	0.012528	2,473,710	30,991	65.00
66.00	06600	PHYSICAL THERAPY	62,194	6,024,688	0.010323	1,277,539	13,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	274,634	14,916,300	0.018412	2,193,749	40,391	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,314	6,540,413	0.007081	2,431,768	17,219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,255	14,490,091	0.010231	4,864,338	49,767	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	147,937	8,859,341	0.016698	2,026,985	33,847	73.00
74.00	07400	RENAL DIALYSIS	3,179	761,502	0.004175	109,305	456	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	179,253	5,086,591	0.035240	6,725	237	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	283,350	33,537,891	0.008449	2,697,565	22,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	146,451	3,724,242	0.039324	409,932	16,120	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,033,322	316,288,508		47,131,706	439,957	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part III Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	7,382	0.00	3,443	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,497	0.00	897	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,663	0.00	1,928	0		40.00
43.00	04300	NURSERY	802	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,803	0.00	2,991	0		44.00
200.00		Total (lines 30-199)	16,147		9,259	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	73,592,931	0.000000	0.000000	12,343,586	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,646,680	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	24,953,446	0.000000	0.000000	4,328,620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,044,735	0.000000	0.000000	4,621,068	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	61,951,223	0.000000	0.000000	7,346,816	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,158,434	0.000000	0.000000	2,473,710	65.00
66.00	06600	PHYSICAL THERAPY	0	6,024,688	0.000000	0.000000	1,277,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,916,300	0.000000	0.000000	2,193,749	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,540,413	0.000000	0.000000	2,431,768	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,490,091	0.000000	0.000000	4,864,338	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,859,341	0.000000	0.000000	2,026,985	73.00
74.00	07400	RENAL DIALYSIS	0	761,502	0.000000	0.000000	109,305	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03950	WOUND CARE	0	5,086,591	0.000000	0.000000	6,725	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	33,537,891	0.000000	0.000000	2,697,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,724,242	0.000000	0.000000	409,932	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	316,288,508			47,131,706	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	14,216,007	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	4,038,444	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,411,265	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	3,746,847	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	602,653	0		65.00
66.00	06600	PHYSICAL THERAPY	0	21,326	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	4,559,586	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	313,255	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,831,273	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,528,869	0		73.00
74.00	07400	RENAL DIALYSIS	0	10,469	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03950	WOUND CARE	0	1,946,137	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	4,611,538	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	930,245	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	49,767,914	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.073815	14,216,007	0	0	1,049,355	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.396619	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.098035	4,038,444	0	0	395,909	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082651	11,411,265	0	0	943,152	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.063670	3,746,847	0	0	238,562	60.00
65.00	06500	RESPIRATORY THERAPY	0.122304	602,653	0	0	73,707	65.00
66.00	06600	PHYSICAL THERAPY	0.199818	21,326	0	0	4,261	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114808	4,559,586	0	0	523,477	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.127880	313,255	0	0	40,059	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.169273	1,831,273	0	0	309,985	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348585	1,528,869	0	11,548	532,941	73.00
74.00	07400	RENAL DIALYSIS	0.238762	10,469	0	0	2,500	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.242355	1,946,137	0	0	471,656	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.097072	4,611,538	0	156	447,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255121	930,245	0	0	237,325	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		49,767,914	0	11,704	5,270,540	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		49,767,914	0	11,704	5,270,540	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
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
60.00	06000	LABORATORY	0	0		60.00
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	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,025		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	15		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	4,040		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,040		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part II Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	695,146	73,592,931	0.009446	1,348	13	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,550	1,646,680	0.020982	0	0	52.00
53.00	05300	ANESTHESIOLOGY	87,820	24,953,446	0.003519	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	482,169	52,044,735	0.009265	360,518	3,340	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	339,864	61,951,223	0.005486	950,216	5,213	60.00
65.00	06500	RESPIRATORY THERAPY	102,206	8,158,434	0.012528	232,605	2,914	65.00
66.00	06600	PHYSICAL THERAPY	62,194	6,024,688	0.010323	318,714	3,290	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	274,634	14,916,300	0.018412	98,527	1,814	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,314	6,540,413	0.007081	4,992	35	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,255	14,490,091	0.010231	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	147,937	8,859,341	0.016698	409,657	6,840	73.00
74.00	07400	RENAL DIALYSIS	3,179	761,502	0.004175	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	179,253	5,086,591	0.035240	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	283,350	33,537,891	0.008449	171,269	1,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,724,242	0.000000	26,743	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,886,871	316,288,508		2,574,589	24,906	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	73,592,931	0.000000	0.000000	1,348	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,646,680	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	24,953,446	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,044,735	0.000000	0.000000	360,518	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	61,951,223	0.000000	0.000000	950,216	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,158,434	0.000000	0.000000	232,605	65.00
66.00	06600	PHYSICAL THERAPY	0	6,024,688	0.000000	0.000000	318,714	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,916,300	0.000000	0.000000	98,527	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,540,413	0.000000	0.000000	4,992	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,490,091	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,859,341	0.000000	0.000000	409,657	73.00
74.00	07400	RENAL DIALYSIS	0	761,502	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03950	WOUND CARE	0	5,086,591	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	33,537,891	0.000000	0.000000	171,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,724,242	0.000000	0.000000	26,743	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	316,288,508			2,574,589	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	2,485	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	2,485	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.073815	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.396619	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.098035	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082651	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.063670	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.122304	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.199818	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114808	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.127880	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.169273	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348585	0	0	3,019	0	73.00
74.00	07400	RENAL DIALYSIS	0.238762	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.242355	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.097072	2,485	0	0	241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255121	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		2,485	0	3,019	241	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,485	0	3,019	241	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
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
60.00	06000	LABORATORY	0	0		60.00
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	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,052		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	1,052		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	1,052		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	73,592,931	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,646,680	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	24,953,446	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,044,735	0.000000	0.000000	169,967	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	61,951,223	0.000000	0.000000	1,122,778	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,158,434	0.000000	0.000000	1,190,092	65.00
66.00	06600	PHYSICAL THERAPY	0	6,024,688	0.000000	0.000000	2,367,211	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,916,300	0.000000	0.000000	80,880	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,540,413	0.000000	0.000000	1,055,550	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,490,091	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,859,341	0.000000	0.000000	737,371	73.00
74.00	07400	RENAL DIALYSIS	0	761,502	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03950	WOUND CARE	0	5,086,591	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	33,537,891	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,724,242	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	316,288,508			6,723,849	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part I Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,262,975	0	1,262,975	7,382	171.09	30.00
31.00	INTENSIVE CARE UNIT	255,488		255,488	1,497	170.67	31.00
40.00	SUBPROVIDER - IPF	302,223	0	302,223	2,663	113.49	40.00
43.00	NURSERY	53,747		53,747	802	67.02	43.00
44.00	SKILLED NURSING FACILITY	535,868		535,868	3,803	140.91	44.00
200.00	Total (lines 30-199)	2,410,301		2,410,301	16,147		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	290	49,616		30.00
31.00	INTENSIVE CARE UNIT	18	3,072		31.00
40.00	SUBPROVIDER - IPF	0	0		40.00
43.00	NURSERY	567	38,000		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	875	90,688		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part II Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	695,146	73,592,931	0.009446	3,852,607	36,392	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,550	1,646,680	0.020982	972,850	20,412	52.00
53.00	05300	ANESTHESIOLOGY	87,820	24,953,446	0.003519	1,619,278	5,698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	482,169	52,044,735	0.009265	640,890	5,938	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	339,864	61,951,223	0.005486	1,743,939	9,567	60.00
65.00	06500	RESPIRATORY THERAPY	102,206	8,158,434	0.012528	276,352	3,462	65.00
66.00	06600	PHYSICAL THERAPY	62,194	6,024,688	0.010323	182,775	1,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	274,634	14,916,300	0.018412	130,481	2,402	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,314	6,540,413	0.007081	1,102,808	7,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	148,255	14,490,091	0.010231	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	147,937	8,859,341	0.016698	524,015	8,750	73.00
74.00	07400	RENAL DIALYSIS	3,179	761,502	0.004175	9,155	38	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03950	WOUND CARE	179,253	5,086,591	0.035240	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	283,350	33,537,891	0.008449	126,024	1,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	146,451	3,724,242	0.039324	84,210	3,311	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,033,322	316,288,508		11,265,384	106,731	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part III Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	7,382	0.00	290	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,497	0.00	18	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,663	0.00	0	0		40.00
43.00	04300	NURSERY	802	0.00	567	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,803	0.00	0	0		44.00
200.00		Total (lines 30-199)	16,147		875	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV | Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	73,592,931	0.000000	0.000000	3,852,607	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,646,680	0.000000	0.000000	972,850	52.00
53.00	05300	ANESTHESIOLOGY	0	24,953,446	0.000000	0.000000	1,619,278	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,044,735	0.000000	0.000000	640,890	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	61,951,223	0.000000	0.000000	1,743,939	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,158,434	0.000000	0.000000	276,352	65.00
66.00	06600	PHYSICAL THERAPY	0	6,024,688	0.000000	0.000000	182,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,916,300	0.000000	0.000000	130,481	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,540,413	0.000000	0.000000	1,102,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,490,091	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,859,341	0.000000	0.000000	524,015	73.00
74.00	07400	RENAL DIALYSIS	0	761,502	0.000000	0.000000	9,155	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03950	WOUND CARE	0	5,086,591	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	33,537,891	0.000000	0.000000	126,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,724,242	0.000000	0.000000	84,210	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	316,288,508			11,265,384	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV | Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,382	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,382	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)	6,526	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)	3,443	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)	8,193,826	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)	8,193,826	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)	8,193,826	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,109.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,821,627	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,821,627	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,059,328	1,497	2,043.64	897	1,833,145	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)	5,230,006	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,884,778	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)	742,154	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	439,957	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,182,111	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,702,667	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	856	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,109.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	950,134	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,262,975	8,193,826	0.154137	950,134	146,451	90.00
91.00	Nursing School cost	0	8,193,826	0.000000	950,134	0	91.00
92.00	Allied health cost	0	8,193,826	0.000000	950,134	0	92.00
93.00	All other Medical Education	0	8,193,826	0.000000	950,134	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,663	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,663	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,663	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,928	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,491,607	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,491,607	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,491,607	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)	935.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,803,914	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,803,914	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	360,729	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,164,643	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)	218,809	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	24,906	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	243,715	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,920,928	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1

Component CCN: 14S040 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	302,223	2,491,607	0.121296	0	0	90.00
91.00	Nursing School cost	0	2,491,607	0.000000	0	0	91.00
92.00	Allied health cost	0	2,491,607	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,491,607	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 145690	Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,803	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,803	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,803	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,991	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)	3,355,204	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)	3,355,204	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)	3,355,204	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,355,204	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	882.25	71.00
72.00	Program routine service cost (line 9 x line 71)	2,638,810	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,638,810	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,638,810	83.00
84.00	Program inpatient ancillary services (see instructions)	1,105,405	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,744,215	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1

Component CCN: 145690 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,382	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,382	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)	6,526	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)	290	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)	802	15.00
16.00	Nursery days (title V or XIX only)	567	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)	8,193,826	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)	8,193,826	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)	8,193,826	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,109.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	321,891	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)	321,891	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	680,239	802	848.18	567	480,918	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,059,328	1,497	2,043.64	18	36,786	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,437,879	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,277,474	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)	90,688	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	106,731	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	197,419	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,080,055	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	856	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,109.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	950,134	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,262,975	8,193,826	0.154137	950,134	146,451	90.00
91.00	Nursing School cost	0	8,193,826	0.000000	950,134	0	91.00
92.00	Allied health cost	0	8,193,826	0.000000	950,134	0	92.00
93.00	All other Medical Education	0	8,193,826	0.000000	950,134	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-3 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,851,279		30.00
31.00	03100	INTENSIVE CARE UNIT		5,448,260		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.073815	12,343,586	911,142	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.396619	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.098035	4,328,620	424,356	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082651	4,621,068	381,936	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.063670	7,346,816	467,772	60.00
65.00	06500	RESPIRATORY THERAPY	0.122304	2,473,710	302,545	65.00
66.00	06600	PHYSICAL THERAPY	0.199818	1,277,539	255,275	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114808	2,193,749	251,860	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.127880	2,431,768	310,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.169273	4,864,338	823,401	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348585	2,026,985	706,577	73.00
74.00	07400	RENAL DIALYSIS	0.238762	109,305	26,098	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03950	WOUND CARE	0.242355	6,725	1,630	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.097072	2,697,565	261,858	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255121	409,932	104,582	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		47,131,706	5,230,006	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)		47,131,706		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-3 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		4,950,004		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.073815	1,348	100	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.396619	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.098035	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082651	360,518	29,797	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.063670	950,216	60,500	60.00
65.00	06500	RESPIRATORY THERAPY	0.122304	232,605	28,449	65.00
66.00	06600	PHYSICAL THERAPY	0.199818	318,714	63,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114808	98,527	11,312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.127880	4,992	638	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.169273	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348585	409,657	142,800	73.00
74.00	07400	RENAL DIALYSIS	0.238762	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03950	WOUND CARE	0.242355	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.097072	171,269	16,625	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255121	26,743	6,823	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,574,589	360,729	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,574,589		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-3 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.073815	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.396619	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.098035	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082651	169,967	14,048	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.063670	1,122,778	71,487	60.00
65.00	06500	RESPIRATORY THERAPY	0.122304	1,190,092	145,553	65.00
66.00	06600	PHYSICAL THERAPY	0.199818	2,367,211	473,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114808	80,880	9,286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.127880	1,055,550	134,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.169273	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348585	737,371	257,036	73.00
74.00	07400	RENAL DIALYSIS	0.238762	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03950	WOUND CARE	0.242355	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.097072	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255121	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		6,723,849	1,105,405	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		6,723,849		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-3 | Date/Time Prepared: 9/27/2016 1:05 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,367,633		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.073815	3,852,607	284,380	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.396619	972,850	385,851	52.00
53.00	05300	ANESTHESIOLOGY	0.098035	1,619,278	158,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.082651	640,890	52,970	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.063670	1,743,939	111,037	60.00
65.00	06500	RESPIRATORY THERAPY	0.122304	276,352	33,799	65.00
66.00	06600	PHYSICAL THERAPY	0.199818	182,775	36,522	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114808	130,481	14,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.127880	1,102,808	141,027	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.169273	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348585	524,015	182,664	73.00
74.00	07400	RENAL DIALYSIS	0.238762	9,155	2,186	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03950	WOUND CARE	0.242355	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.097072	126,024	12,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255121	84,210	21,484	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		11,265,384	1,437,879	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)		11,265,384		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E Part A Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,835,151	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,969,212	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)	86,440	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	93.66	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	6.48	30.00
31.00	Percentage of Medicaid patient days (see instructions)	21.96	31.00
32.00	Sum of lines 30 and 31	28.44	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.68	33.00
34.00	Disproportionate share adjustment (see instructions)	215,698	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000067398	0.000067010	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	515,438	429,275	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	216,060	249,824	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	465,884		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	7,572,385		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	7,888,395		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	7,809,393	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	561,093	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)	8,370,486	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	8,370,486	61.00
62.00	Deductibles billed to program beneficiaries	836,062	62.00
63.00	Coinsurance billed to program beneficiaries	68,474	63.00
64.00	Allowable bad debts (see instructions)	301,990	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	196,294	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	205,166	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	7,662,244	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	371	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-3,452	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	10,821	70.93
70.94	HRR adjustment amount (see instructions)	-98,318	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	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)		7,571,666	71.00
71.01	Sequestration adjustment (see instructions)		151,433	71.01
72.00	Interim payments		7,142,588	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)		277,645	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		801,030	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	99,077	137,931	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0003903257	1.0024087420	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	39	332	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9802	0.9892	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-1,962	-1,490	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,040	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,270,540	2.00
3.00	PPS payments	4,213,533	3.00
4.00	Outlier payment (see instructions)	74,436	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)	4,040	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	11,704	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	11,704	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	11,704	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	7,664	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)	4,040	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,287,969	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	881,932	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,410,077	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,410,077	30.00
31.00	Primary payer payments	3,897	31.00
32.00	Subtotal (line 30 minus line 31)	3,406,180	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)	261,940	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	170,261	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	201,325	36.00
37.00	Subtotal (see instructions)	3,576,441	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)	3,576,441	40.00
40.01	Sequestration adjustment (see instructions)	71,529	40.01
41.00	Interim payments	3,457,753	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	47,159	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,052	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	241	2.00
3.00	PPS payments	719	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)	1,052	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,019	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	3,019	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)	3,019	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,967	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)	1,052	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)	719	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,771	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)	1,771	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,771	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,771	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)	1,771	40.00
40.01	Sequestration adjustment (see instructions)	35	40.01
41.00	Interim payments	1,297	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	439	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: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,142,588		3,457,753	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7,142,588		3,457,753	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		277,645		47,159	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,420,233		3,504,912	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,746,991		1,297	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,746,991		1,297	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		30,059		439	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,777,050		1,736	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 9/27/2016 1:05 pm

Title XVIII | Skilled Nursing Facility | 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		1,077,633		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,077,633		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,868		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,079,501		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet E-1 Part II Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,230	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	4,340	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,481	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	8,023	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	358,909,300	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	108,108	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)	804,259	8.00
9.00	Sequestration adjustment amount (see instructions)	16,085	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	788,174	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	806,461	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)	-18,287	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2015 To 04/30/2016	Worksheet E-3 Part II Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,786,773	1.00
2.00	Net IPF PPS Outlier Payments	107,537	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	7.275956	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,894,310	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,894,310	16.00
17.00	Primary payer payments	171	17.00
18.00	Subtotal (line 16 less line 17).	1,894,139	18.00
19.00	Deductibles	70,980	19.00
20.00	Subtotal (line 18 minus line 19)	1,823,159	20.00
21.00	Coinsurance	40,516	21.00
22.00	Subtotal (line 20 minus line 21)	1,782,643	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,189	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	30,673	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	40,552	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,813,316	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,813,316	31.00
31.01	Sequestration adjustment (see instructions)	36,266	31.01
32.00	Interim payments	1,746,991	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	30,059	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	107,537	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 145690	Period: From 05/01/2015 To 04/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,215,272	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,215,272	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	780	6.00
7.00	Coinsurance	114,867	7.00
8.00	Allowable bad debts (see instructions)	2,934	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	1,907	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,101,532	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,101,532	15.00
15.01	Sequestration adjustment (see instructions)	22,031	15.01
16.00	Interim payments	1,077,633	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	1,868	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G | Date/Time Prepared: 9/27/2016 1:05 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	-394,090	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,720,547	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,353,740	0	0	0	6.00
7.00	Inventory	1,460,812	0	0	0	7.00
8.00	Prepaid expenses	737,037	0	0	0	8.00
9.00	Other current assets	-59,280	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)	12,111,286	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	433,029	0	0	0	12.00
13.00	Land improvements	621,460	0	0	0	13.00
14.00	Accumulated depreciation	-424,376	0	0	0	14.00
15.00	Buildings	15,696,873	0	0	0	15.00
16.00	Accumulated depreciation	-6,151,129	0	0	0	16.00
17.00	Leasehold improvements	10,190,244	0	0	0	17.00
18.00	Accumulated depreciation	-4,783,499	0	0	0	18.00
19.00	Fixed equipment	3,933,574	0	0	0	19.00
20.00	Accumulated depreciation	-1,431,007	0	0	0	20.00
21.00	Automobiles and trucks	31,608	0	0	0	21.00
22.00	Accumulated depreciation	-31,608	0	0	0	22.00
23.00	Major movable equipment	12,824,302	0	0	0	23.00
24.00	Accumulated depreciation	-9,450,337	0	0	0	24.00
25.00	Minor equipment depreciable	5,487,179	0	0	0	25.00
26.00	Accumulated depreciation	-4,490,701	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,455,612	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	3,507,853	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,507,853	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,074,751	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,959,839	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,202,941	0	0	0	38.00
39.00	Payroll taxes payable	183,543	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	-129,086,754	0	0	0	43.00
44.00	Other current liabilities	541,814	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-124,198,617	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-124,198,617	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	162,273,368				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)	162,273,368	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,074,751	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-1 | Date/Time Prepared: 9/27/2016 1:05 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		150,743,742		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,529,626				2.00
3.00	Total (sum of line 1 and line 2)		162,273,368		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		162,273,368		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		162,273,368		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/27/2016 1:05 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,345,555		21,345,555	1.00
2.00	SUBPROVIDER - IPF	9,131,613		9,131,613	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	3,064,482		3,064,482	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)	33,541,650		33,541,650	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,079,142		9,079,142	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)	9,079,142		9,079,142	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,620,792		42,620,792	17.00
18.00	Ancillary services	96,926,081	182,100,294	279,026,375	18.00
19.00	Outpatient services	5,521,709	31,740,424	37,262,133	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				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	INDUSTRIAL LAB REVENUE	0	-2,921,489	-2,921,489	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	145,068,582	210,919,229	355,987,811	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		53,562,467		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)		53,562,467		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet G-3 Date/Time Prepared: 9/27/2016 1:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	355,987,811	1.00
2.00	Less contractual allowances and discounts on patients' accounts	291,875,444	2.00
3.00	Net patient revenues (line 1 minus line 2)	64,112,367	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	53,562,467	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,549,900	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	979,726	24.00
25.00	Total other income (sum of lines 6-24)	979,726	25.00
26.00	Total (line 5 plus line 25)	11,529,626	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,529,626	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 140040 | Period: From 05/01/2015 To 04/30/2016 | Worksheet I-5 | Date/Time Prepared: 9/27/2016 1:05 pm

		1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140040	Period: From 05/01/2015 To 04/30/2016	Worksheet L Parts I-III Date/Time Prepared: 9/27/2016 1:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	542,686	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	18,407	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)	22.31	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	561,093	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