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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/28/2016 10:36 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/28/2016 Time: 10:36 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PEKIN MEMORIAL HOSPITAL (140120) for the cost reporting period beginning 05/01/2015 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	72,376	-926	-14,358	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	72,376	-926	-14,358	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 9:11 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 SOUTH 13TH STREET	PO Box:			1.00
2.00	City: PEKIN	State: IL	Zip Code: 61554	County: TAZWELL	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PEKIN MEMORIAL HOSPITAL	140120	37900	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PEKIN HOME HEALTH	147057	37900		01/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	499	964	0	0	984	71	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 9:11 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 9:11 am

		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: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 9:11 am

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	380,011	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
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: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/28/2016 9:11 am

		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	14H076	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PROGRESSIVE HEALTH SYSTEMS	Contractor's Name: NATIONAL GOVERNMENT SERVICES, INC	Contractor's Number: 00131	141.00
142.00	Street: 600 SOUTH 13TH STREET	PO Box:		142.00
143.00	City: PEKIN	State: IL	Zip Code: 61554	143.00

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

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

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

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

		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)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 9:11 am

		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)	05/01/2015	04/30/2016	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/28/2016 9:11 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/21/2016	Y	09/21/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 9/28/2016 9:11 am

		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.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	Y		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/28/2016 9:11 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 9/28/2016 9:11 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	99	36,234	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		99	36,234	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		107	39,162	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		107				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 9/28/2016 9:11 am

	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)	5,751	362	11,183			1.00
2.00	HMO and other (see instructions)	2,223	1,586				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,751	362	11,183			7.00
8.00	INTENSIVE CARE UNIT	559	43	1,353			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		456	802			13.00
14.00	Total (see instructions)	6,310	861	13,338	0.00	531.62	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,611	0	7,598	0.00	5.83	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	537.45	27.00
28.00	Observation Bed Days		427	1,400			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			106			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	71	120			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 9/28/2016 9:11 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,341	233	3,198	1.00
2.00	HMO and other (see instructions)			474	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	1,341	233	3,198	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 9/28/2016 9:11 am

		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	25,821,422	0	25,821,422	1,119,398.51	23.07	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		2,154,490	0	2,154,490	51,039.00	42.21	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		378,452	11	378,463	13,920.75	27.19	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,629,509	0	1,629,509	23,660.00	68.87	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		12,000	0	12,000	120.00	100.00	13.00
14.00	Home office salaries & wage-related costs		1,745,693	0	1,745,693	41,550.00	42.01	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)		6,878,335	0	6,878,335			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		93,653	0	93,653			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	0	201,810	201,810	8,844.50	22.82	26.00
27.00	Administrative & General	5.00	5,575,148	-201,810	5,373,338	239,857.46	22.40	27.00
28.00	Administrative & General under contract (see inst.)		811,272	0	811,272	3,519.58	230.50	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	510,730	0	510,730	22,358.00	22.84	30.00
31.00	Laundry & Linen Service	8.00	187,414	0	187,414	14,612.19	12.83	31.00
32.00	Housekeeping	9.00	639,284	0	639,284	58,514.03	10.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	787,367	-646,241	141,126	11,615.73	12.15	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	646,241	646,241	53,204.17	12.15	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	766,711	0	766,711	23,383.90	32.79	38.00
39.00	Central Services and Supply	14.00	105,565	0	105,565	6,946.60	15.20	39.00
40.00	Pharmacy	15.00	781,987	-781,987	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 9/28/2016 9:11 am

		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	627,232	0	627,232	34,644.19	18.10	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 9/28/2016 9:11 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		24,478,204	0	24,478,204	1,071,879.09	22.84	1.00
2.00	Excluded area salaries (see instructions)		378,452	11	378,463	13,920.75	27.19	2.00
3.00	Subtotal salaries (line 1 minus line 2)		24,099,752	-11	24,099,741	1,057,958.34	22.78	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,387,202	0	3,387,202	65,330.00	51.85	4.00
5.00	Subtotal wage-related costs (see inst.)		6,878,335	0	6,878,335	0.00	28.54	5.00
6.00	Total (sum of lines 3 thru 5)		34,365,289	-11	34,365,278	1,123,288.34	30.59	6.00
7.00	Total overhead cost (see instructions)		10,792,710	-781,987	10,010,723	477,500.35	20.96	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 9/28/2016 9:11 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	707,148	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	300,806	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	20,637	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)	3,482,163	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	40,618	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	406,799	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	1,908,125	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	81,960	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	23,732	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,971,988	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 9/28/2016 9:11 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,751,688	122,576	1.00
2.00	Hospital	2,440,781	122,576	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	310,907	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140120 | Component CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-4 | Date/Time Prepared: 9/28/2016 9:11 am

Home Health Agency I | PPS

						1.00	
0.00	County					TAZWELL	0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	359.00	28.00	58.00	445.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			1.00	0.00	1.00	5.00
6.00	Direct Nursing Service			5.90	0.00	5.90	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.15	0.00	0.15	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			37900			20.00
20.01				99914			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,090	0	34	24	1,148	21.00
22.00	Skilled Nursing Visit Charges	189,486	0	5,916	4,176	199,578	22.00
23.00	Physical Therapy Visits	1,620	0	14	35	1,669	23.00
24.00	Physical Therapy Visit Charges	307,800	0	2,660	6,650	317,110	24.00
25.00	Occupational Therapy Visits	607	0	3	20	630	25.00
26.00	Occupational Therapy Visit Charges	116,544	0	576	3,840	120,960	26.00
27.00	Speech Pathology Visits	16	0	0	0	16	27.00
28.00	Speech Pathology Visit Charges	3,312	0	0	0	3,312	28.00
29.00	Medical Social Service Visits	1	0	0	0	1	29.00
30.00	Medical Social Service Visit Charges	279	0	0	0	279	30.00
31.00	Home Health Aide Visits	146	0	0	1	147	31.00
32.00	Home Health Aide Visit Charges	11,534	0	0	79	11,613	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,480	0	51	80	3,611	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	628,955	0	9,152	14,745	652,852	35.00
36.00	Total Number of Episodes (standard/non outlier)	209		14	6	229	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	5,098	0	267	80	5,445	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-10 | Date/Time Prepared: 9/28/2016 9:11 am

		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)	0.260153	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,466,692	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,898,933	5.00
6.00	Medicaid charges	51,986,665	6.00
7.00	Medicaid cost (line 1 times line 6)	13,524,487	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)	4,158,862	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	25,556	9.00
10.00	Stand-alone SCHIP charges	240,967	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	62,688	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	37,132	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)	4,195,994	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	644,737	428,507	1,073,244	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	167,730	111,477	279,207	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)	167,730	111,477	279,207	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)	4,805,391	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	211,254	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,594,137	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,195,179	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,474,386	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,670,380	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A | Date/Time Prepared: 9/28/2016 9:11 am

		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		1,492,271	1,492,271	519,704	2,011,975	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,235,329	2,235,329	42,636	2,277,965	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,925,617	6,925,617	467,136	7,392,753	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,575,148	14,282,312	19,857,460	-1,083,664	18,773,796	5.00
7.00	00700	OPERATION OF PLANT	510,730	1,783,695	2,294,425	18,176	2,312,601	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	187,414	96,578	283,992	0	283,992	8.00
9.00	00900	HOUSEKEEPING	639,284	390,533	1,029,817	0	1,029,817	9.00
10.00	01000	DIETARY	787,367	832,717	1,620,084	-1,329,704	290,380	10.00
11.00	01100	CAFETERIA	0	0	0	1,329,704	1,329,704	11.00
13.00	01300	NURSING ADMINISTRATION	766,711	187,642	954,353	-104	954,249	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,565	213,224	318,789	-247,427	71,362	14.00
15.00	01500	PHARMACY	781,987	2,413,573	3,195,560	-2,891,355	304,205	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	627,232	252,047	879,279	0	879,279	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,344,684	679,802	6,024,486	-1,130,729	4,893,757	30.00
31.00	03100	INTENSIVE CARE UNIT	1,141,568	50,627	1,192,195	22,705	1,214,900	31.00
43.00	04300	NURSERY	0	0	0	236,054	236,054	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,441,920	4,536,157	6,978,077	-4,135,113	2,842,964	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	689,030	689,030	52.00
53.00	05300	ANESTHESIOLOGY	0	1,585,022	1,585,022	-177,470	1,407,552	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,354,327	359,579	1,713,906	81,017	1,794,923	54.00
56.00	05600	RADIOISOTOPE	141,915	279,995	421,910	-1,479	420,431	56.00
57.00	05700	CT SCAN	197,721	206,464	404,185	33,321	437,506	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	169,359	52,337	221,696	-7,177	214,519	58.00
59.00	05900	CARDIAC CATHETERIZATION	163,276	509,695	672,971	-446,878	226,093	59.00
60.00	06000	LABORATORY	1,152,758	1,300,418	2,453,176	-69,175	2,384,001	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	388,863	388,863	58,811	447,674	63.00
65.00	06500	RESPIRATORY THERAPY	390,841	90,872	481,713	-51,729	429,984	65.00
66.00	06600	PHYSICAL THERAPY	0	721,112	721,112	-978	720,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	81,049	81,049	0	81,049	67.00
68.00	06800	SPEECH PATHOLOGY	0	56,958	56,958	130	57,088	68.00
69.00	06900	ELECTROCARDIOLOGY	393,945	330,288	724,233	6,102	730,335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	179	179	3,681,703	3,681,882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,304,814	2,304,814	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,916,010	2,916,010	73.00
76.00	03610	SLEEP LAB	0	111,675	111,675	-6	111,669	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	437,598	1,198,826	1,636,424	-119,446	1,516,978	90.00
91.00	09100	EMERGENCY	2,131,620	3,578,764	5,710,384	-257,485	5,452,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	360,238	412,653	772,891	-6,854	766,037	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		450,280	450,280	-450,280	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,803,208	48,087,153	73,890,361	0	73,890,361	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,214	1,108	19,322	0	19,322	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	25,821,422	48,088,261	73,909,683	0	73,909,683	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A | Date/Time Prepared: 9/28/2016 9:11 am

		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	6,658	2,018,633		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-222,869	2,055,096		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,050,922	6,341,831		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,436,010	13,337,786		5.00
7.00	00700	OPERATION OF PLANT	0	2,312,601		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	283,992		8.00
9.00	00900	HOUSEKEEPING	-72,060	957,757		9.00
10.00	01000	DIETARY	0	290,380		10.00
11.00	01100	CAFETERIA	-570,069	759,635		11.00
13.00	01300	NURSING ADMINISTRATION	-127,049	827,200		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,362		14.00
15.00	01500	PHARMACY	-3	304,202		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-28,912	850,367		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-5,761	4,887,996		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,214,900		31.00
43.00	04300	NURSERY	-455	235,599		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,842,964		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	689,030		52.00
53.00	05300	ANESTHESIOLOGY	-1,407,552	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,223	1,787,700		54.00
56.00	05600	RADIOISOTOPE	0	420,431		56.00
57.00	05700	CT SCAN	0	437,506		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	214,519		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	226,093		59.00
60.00	06000	LABORATORY	-67,500	2,316,501		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	447,674		63.00
65.00	06500	RESPIRATORY THERAPY	0	429,984		65.00
66.00	06600	PHYSICAL THERAPY	-8,293	711,841		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	81,049		67.00
68.00	06800	SPEECH PATHOLOGY	0	57,088		68.00
69.00	06900	ELECTROCARDIOLOGY	-289,251	441,084		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-414	3,681,468		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,304,814		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,916,010		73.00
76.00	03610	SLEEP LAB	-111,600	69		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-70	1,516,908		90.00
91.00	09100	EMERGENCY	0	5,452,899		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-1,581	764,456		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,400,936	64,489,425		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,322		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	LEASED SPACE	0	0		194.01
194.02	07952	FOUNDATION	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-9,400,936	64,508,747		200.00

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	646,241	683,463		1.00
	TOTALS		646,241	683,463		
	B - TO RECLASS BLOOD SALARIES FROM LAB					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	59,611	0		1.00
	TOTALS		59,611	0		
	C - TO RECLASS LDR EXPENSES					
1.00	NURSERY	43.00	226,168	7,393		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	660,274	21,584		2.00
	TOTALS		886,442	28,977		
	D - TO RECLASS CLINICAL ENGINEERING EXPE					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,153		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	10,835		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	23,736		3.00
4.00	NURSERY	43.00	0	2,455		4.00
5.00	OPERATING ROOM	50.00	0	112,520		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,168		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	131,800		7.00
8.00	RADIOISOTOPE	56.00	0	1,854		8.00
9.00	CT SCAN	57.00	0	74,977		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	58,283		10.00
11.00	LABORATORY	60.00	0	28,508		11.00
12.00	RESPIRATORY THERAPY	65.00	0	18,246		12.00
13.00	PHYSICAL THERAPY	66.00	0	1,628		13.00
14.00	SPEECH PATHOLOGY	68.00	0	130		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	9,924		15.00
16.00	CLINIC	90.00	0	5,619		16.00
17.00	EMERGENCY	91.00	0	11,673		17.00
18.00	HOME HEALTH AGENCY	101.00	0	128		18.00
	TOTALS		0	501,637		
	E - TO RECLASS SUPPLY COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,681,703		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,304,814		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	TOTALS		0	5,986,517		
	F - TO RECLASS BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,175,343		1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,028		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	2,176,371		
	G - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,104		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
	TOTALS		0	2,104		

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	H - TO RECLASS HUMAN RESOURCES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	201,810	265,326		1.00
	TOTALS		201,810	265,326		
	I - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	450,280		1.00
	TOTALS		0	450,280		
	J - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	112,060		1.00
	TOTALS		0	112,060		
	K - TO RECLASS MRI LEASE EXPENSE					
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,935		1.00
	TOTALS		0	4,935		
	L - TO RECLASS MRI BUILDING UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	18,176		1.00
	TOTALS		0	18,176		
	M - TO RECLASS PHARMACY SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	955	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	3	0		2.00
3.00	NURSERY	43.00	38	0		3.00
4.00	OPERATING ROOM	50.00	12,333	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	4	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	3,236	0		6.00
7.00	RADIOISOTOPE	56.00	90	0		7.00
8.00	CT SCAN	57.00	4	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	7,856	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	479	0		10.00
11.00	LABORATORY	60.00	105	0		11.00
12.00	RESPIRATORY THERAPY	65.00	58	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	740,667	0		13.00
14.00	CLINIC	90.00	14,865	0		14.00
15.00	EMERGENCY	91.00	1,283	0		15.00
16.00	HOME HEALTH AGENCY	101.00	11	0		16.00
	TOTALS		781,987	0		
	N - TO RECLASS ANESTHESIOLOGY EXPENSE					
1.00	OPERATING ROOM	50.00	0	177,470		1.00
	TOTALS		0	177,470		
500.00	Grand Total: Increases		2,576,091	10,407,316		500.00

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-6 | Date/Time Prepared: 9/28/2016 9:11 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	646,241	683,463	0		1.00
	TOTALS		646,241	683,463			
	B - TO RECLASS BLOOD SALARIES FROM LAB						
1.00	LABORATORY	60.00	59,611	0	0		1.00
	TOTALS		59,611	0			
	C - TO RECLASS LDR EXPENSES						
1.00	ADULTS & PEDIATRICS	30.00	886,442	28,977	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		886,442	28,977			
	D - TO RECLASS CLINICAL ENGINEERING EXPE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	501,637	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
	TOTALS		0	501,637			
	E - TO RECLASS SUPPLY COSTS						
1.00	NURSING ADMINISTRATION	13.00	0	104	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	234,290	0		2.00
3.00	PHARMACY	15.00	0	10,674	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	226,638	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	1,034	0		5.00
6.00	OPERATING ROOM	50.00	0	4,428,329	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,000	0		7.00
8.00	RADIOISOTOPE	56.00	0	3,423	0		8.00
9.00	CT SCAN	57.00	0	38,670	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,831	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	505,640	0		11.00
12.00	LABORATORY	60.00	0	38,087	0		12.00
13.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	800	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	70,033	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	2,606	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	3,822	0		16.00
17.00	SLEEP LAB	76.00	0	6	0		17.00
18.00	CLINIC	90.00	0	97,128	0		18.00
19.00	EMERGENCY	91.00	0	263,409	0		19.00
20.00	HOME HEALTH AGENCY	101.00	0	6,993	0		20.00
	TOTALS		0	5,986,517			
	F - TO RECLASS BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	15,290	0		1.00
2.00	PHARMACY	15.00	0	2,098,694	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	462	0		3.00
4.00	OPERATING ROOM	50.00	0	9,071	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30	0		5.00
6.00	CT SCAN	57.00	0	2,990	0		6.00
7.00	CLINIC	90.00	0	42,802	0		7.00
8.00	EMERGENCY	91.00	0	7,032	0		8.00
	TOTALS		0	2,176,371			
	G - TO RECLASS TELEPHONE EXPENSE						
1.00	OPERATING ROOM	50.00	0	36	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	989	0		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	989	0		3.00
4.00	LABORATORY	60.00	0	90	0		4.00
	TOTALS		0	2,104			

RECLASSIFICATIONS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-6 | Date/Time Prepared: 9/28/2016 9:11 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	H - TO RECLASS HUMAN RESOURCES						
1.00	ADMINISTRATIVE & GENERAL	5.00	201,810	265,326	0		1.00
	TOTALS		201,810	265,326			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	450,280	11		1.00
	TOTALS		0	450,280			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	112,060	0		1.00
	TOTALS		0	112,060			
	K - TO RECLASS MRI LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,935	0		1.00
	TOTALS		0	4,935			
	L - TO RECLASS MRI BUILDING UTILITIES						
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	18,176	0		1.00
	TOTALS		0	18,176			
	M - TO RECLASS PHARMACY SALARIES						
1.00	PHARMACY	15.00	781,987	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	TOTALS		781,987	0			
	N - TO RECLASS ANESTHESIOLOGY EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	177,470	0		1.00
	TOTALS		0	177,470			
500.00	Grand Total: Decreases		2,576,091	10,407,316			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part I Date/Time Prepared: 9/28/2016 9:11 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,449,581	0	0	0	0	1.00
2.00	Land Improvements	1,827,216	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	0	0	0	3.00
4.00	Building Improvements	19,494,197	867,810	0	867,810	0	4.00
5.00	Fixed Equipment	18,635,442	480,305	0	480,305	1,100	5.00
6.00	Movable Equipment	32,481,535	2,326,716	0	2,326,716	1,432,323	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,473,917	3,674,831	0	3,674,831	1,433,423	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	85,473,917	3,674,831	0	3,674,831	1,433,423	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,449,581	0	1.00
2.00	Land Improvements	1,827,216	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	3.00
4.00	Building Improvements	20,362,007	0	4.00
5.00	Fixed Equipment	19,114,647	0	5.00
6.00	Movable Equipment	33,375,928	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	87,715,325	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	87,715,325	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 9/28/2016 9:11 am

	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	1,450,598	1,221	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,235,329	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,685,927	1,221	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	40,452	1,492,271		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,235,329		2.00
3.00	Total (sum of lines 1-2)	40,452	3,727,600		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 9/28/2016 9:11 am

	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	54,339,396	0	54,339,396	0.619523	69,424	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	33,375,928	3,663	33,372,265	0.380477	42,636	2.00
3.00	Total (sum of lines 1-2)	87,715,324	3,663	87,711,661	1.000000	112,060	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	69,424	1,450,598	1,221	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	42,636	2,012,460	0	2.00
3.00	Total (sum of lines 1-2)	0	0	112,060	3,463,058	1,221	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	456,938	69,424	0	40,452	2,018,633	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	42,636	0	0	2,055,096	2.00
3.00	Total (sum of lines 1-2)	456,938	112,060	0	40,452	4,073,729	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8 | Date/Time Prepared: 9/28/2016 9:11 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	6,658	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-568,754			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	-5,052,442			0	12.00
13.00	Laundry and linen service	B	-72,060	HOUSEKEEPING	9.00	0	13.00
14.00	Cafeteria-employees and guests	B	-418,168	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-3	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-28,912	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MOW & CATERING	B	-151,901	CAFETERIA	11.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8 | Date/Time Prepared: 9/28/2016 9:11 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	WELLNESS CENTER AND AEROBICS CLASSES	B	-16,253	ELECTROCARDIOLOGY	69.00	0	33.01
33.02	PAIN MANAGEMENT	B	-57,757	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHYSICAL THERAPY OTHER INCOME	B	-8,293	PHYSICAL THERAPY	66.00	0	33.03
33.04	EDUCATION REVENUE	B	-10,393	NURSING ADMINISTRATION	13.00	0	33.04
33.05	SICKBAY REVENUE	B	-560	ADULTS & PEDIATRICS	30.00	0	33.05
33.06	RADIOLOGY TRANSCRIPT REVENUE	B	-7,154	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	NURSERY OTHER INCOME	B	-455	NURSERY	43.00	0	33.07
33.08	ADVERSTISING SALARY EXPENSE	A	-139,497	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ADVERTISING EXPENSE	A	-513,631	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTISING BENEFITS	A	-25,841	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	CRNA - PURCHASED SERVICES	A	-1,407,552	ANESTHESIOLOGY	53.00	0	33.11
33.12	BOOK FAIR PROCEEDS	B	-1,315	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	SELF INSURANCE EXPENSE	A	-941,512	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	HEALTHLINK FEES	A	30,843	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	MARKETING SUPPLIES	A	-31	HOME HEALTH AGENCY	101.00	0	33.15
33.16	PROMOTIONS	A	-2,361	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	PUBLIC RELATIONS	A	-6,288	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	PUBLIC RELATIONS	A	-5,201	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	PUBLIC RELATIONS	A	-69	RADIOLOGY-DIAGNOSTIC	54.00	0	33.19
33.20	PUBLIC RELATIONS	A	-414	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.20
33.21	PUBLIC RELATIONS	A	-70	CLINIC	90.00	0	33.21
33.22	PUBLIC RELATIONS	A	-1,550	HOME HEALTH AGENCY	101.00	0	33.22
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,400,936				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 9/28/2016 9:11 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL REL COSTS- MME	977,290	1,200,159	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE/FINANCE/IS	4,837,734	6,849,793	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PROVIDER TAX HOSPITAL	0	2,733,945	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	383,567	467,136	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,198,591	11,251,033	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:					
6.00	B		100.00	PROGRESSIVE HLT	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet A-8-1 Date/Time Prepared: 9/28/2016 9:11 am

	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	-222,869	9		1.00
2.00	-2,012,059	0		2.00
3.00	-2,733,945	0		3.00
4.00	-83,569	0		4.00
5.00	-5,052,442			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 9/28/2016 9:11 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	76.00	SLEEP LAB	111,600	111,600	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	116,656	116,656	0	0	0	2.00
3.00	60.00	LABORATORY	67,500	67,500	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	281,888	269,888	12,000	154,100	120	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			577,644	565,644	12,000		120	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	76.00	SLEEP LAB	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	8,890	445	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,890	445	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	76.00	SLEEP LAB	0	0	0	111,600		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	116,656		2.00
3.00	60.00	LABORATORY	0	0	0	67,500		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	8,890	3,110	272,998		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	8,890	3,110	568,754		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I Date/Time Prepared: 9/28/2016 9:11 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,018,633	2,018,633				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,055,096		2,055,096			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,341,831	8,800	702	6,351,333		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,337,786	582,568	921,816	1,304,626	16,146,796	5.00
7.00	00700	OPERATION OF PLANT	2,312,601	296,165	23,381	127,308	2,759,455	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	283,992	22,309	22,116	46,716	375,133	8.00
9.00	00900	HOUSEKEEPING	957,757	1,772	5,099	159,352	1,123,980	9.00
10.00	01000	DIETARY	290,380	42,472	5,691	35,178	373,721	10.00
11.00	01100	CAFETERIA	759,635	11,880	20,085	161,086	952,686	11.00
13.00	01300	NURSING ADMINISTRATION	827,200	57,355	41,844	191,115	1,117,514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,362	30,919	60,671	26,314	189,266	14.00
15.00	01500	PHARMACY	304,202	10,227	10,211	0	324,640	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	850,367	25,556	2,674	156,348	1,034,945	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,887,996	246,237	97,179	1,111,526	6,342,938	30.00
31.00	03100	INTENSIVE CARE UNIT	1,214,900	23,701	49,812	284,555	1,572,968	31.00
43.00	04300	NURSERY	235,599	6,160	6,203	56,385	304,347	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,842,964	123,868	298,462	611,762	3,877,056	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	689,030	19,979	18,107	164,585	891,701	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,787,700	93,067	267,567	338,394	2,486,728	54.00
56.00	05600	RADIOISOTOPE	420,431	5,203	2,405	35,397	463,436	56.00
57.00	05700	CT SCAN	437,506	4,578	5,819	49,286	497,189	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	214,519	12,082	372	44,174	271,147	58.00
59.00	05900	CARDIAC CATHETERIZATION	226,093	4,549	26,762	40,819	298,223	59.00
60.00	06000	LABORATORY	2,316,501	35,789	52,025	272,511	2,676,826	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	447,674	0	911	14,859	463,444	63.00
65.00	06500	RESPIRATORY THERAPY	429,984	9,074	21,092	97,438	557,588	65.00
66.00	06600	PHYSICAL THERAPY	711,841	23,487	2,000	0	737,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,049	2,854	58	0	83,961	67.00
68.00	06800	SPEECH PATHOLOGY	57,088	10,988	0	0	68,076	68.00
69.00	06900	ELECTROCARDIOLOGY	441,084	31,669	48,240	98,197	619,190	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,681,468	0	0	0	3,681,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,304,814	0	0	0	2,304,814	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,916,010	0	0	184,623	3,100,633	73.00
76.00	03610	SLEEP LAB	69	4,400	0	0	4,469	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,516,908	12,017	4,985	112,784	1,646,694	90.00
91.00	09100	EMERGENCY	5,452,899	87,484	30,177	531,660	6,102,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	764,456	0	8,562	89,795	862,813	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,489,425	1,847,209	2,055,028	6,346,793	64,313,393	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,322	23,713	68	4,540	47,643	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	108,735	0	0	108,735	192.00
194.00	07950	VACANT SPACE	0	5,863	0	0	5,863	194.00
194.01	07951	LEASED SPACE	0	30,164	0	0	30,164	194.01
194.02	07952	FOUNDATION	0	2,949	0	0	2,949	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	64,508,747	2,018,633	2,055,096	6,351,333	64,508,747	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I Date/Time Prepared: 9/28/2016 9:11 am

		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	16,146,796					5.00
7.00	00700	OPERATION OF PLANT	921,310	3,680,765				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	125,247	72,598	572,978			8.00
9.00	00900	HOUSEKEEPING	375,268	5,766	36,712	1,541,726		9.00
10.00	01000	DIETARY	124,776	138,212	722	59,151	696,582	10.00
11.00	01100	CAFETERIA	318,077	38,660	0	16,545	0	11.00
13.00	01300	NURSING ADMINISTRATION	373,109	186,643	0	79,878	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	63,191	100,616	49,055	43,061	0	14.00
15.00	01500	PHARMACY	108,389	33,281	0	14,243	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	345,541	83,163	0	35,591	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,117,739	801,290	126,787	342,930	630,715	30.00
31.00	03100	INTENSIVE CARE UNIT	525,173	77,126	76,225	33,008	65,867	31.00
43.00	04300	NURSERY	101,614	20,046	8,518	8,579	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,294,448	403,083	87,698	172,508	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	297,716	65,013	24,866	27,824	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	830,254	302,854	41,250	129,613	0	54.00
56.00	05600	RADIOISOTOPE	154,729	16,931	0	7,246	0	56.00
57.00	05700	CT SCAN	165,998	14,899	0	6,376	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	90,529	39,318	2,324	16,827	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	99,569	14,802	0	6,335	0	59.00
60.00	06000	LABORATORY	893,723	116,463	403	49,843	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	154,732	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	186,164	29,527	0	12,637	0	65.00
66.00	06600	PHYSICAL THERAPY	246,175	76,429	8,222	32,710	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,032	9,288	0	3,975	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,729	35,757	0	15,303	0	68.00
69.00	06900	ELECTROCARDIOLOGY	206,731	103,054	1,002	44,104	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,229,146	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	769,517	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,035,221	0	0	0	0	73.00
76.00	03610	SLEEP LAB	1,492	14,318	0	6,128	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	549,788	39,105	0	16,736	0	90.00
91.00	09100	EMERGENCY	2,037,373	284,685	95,804	121,837	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	288,071	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,081,571	3,122,927	559,588	1,302,988	696,582	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,907	77,165	0	33,024	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,304	353,839	13,390	151,433	0	192.00
194.00	07950	VACANT SPACE	1,958	19,078	0	8,165	0	194.00
194.01	07951	LEASED SPACE	10,071	98,159	0	42,009	0	194.01
194.02	07952	FOUNDATION	985	9,597	0	4,107	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,146,796	3,680,765	572,978	1,541,726	696,582	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I Date/Time Prepared: 9/28/2016 9:11 am

		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	1,325,968					11.00
13.00	01300	NURSING ADMINISTRATION	44,392	1,801,536				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,191	0	458,380			14.00
15.00	01500	PHARMACY	1,817	0	587	482,957		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,799	0	860	0	1,565,899	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	349,650	1,510,465	3,704	590	930,558	30.00
31.00	03100	INTENSIVE CARE UNIT	73,579	182,747	109	2	45,224	31.00
43.00	04300	NURSERY	14,969	108,324	151	7	68,132	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	179,110	0	8,524	7,617	334,676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,682	0	442	19	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,678	0	1,181	1,999	0	54.00
56.00	05600	RADIOISOTOPE	7,544	0	52	56	0	56.00
57.00	05700	CT SCAN	14,297	0	31	3	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,863	0	129	4,852	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,649	0	27	296	0	59.00
60.00	06000	LABORATORY	92,063	0	1,926	65	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,016	0	11	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	32,465	0	301	36	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	391	0	128,017	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	28,950	0	423	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	267,070	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	167,187	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,337	0	0	457,435	0	73.00
76.00	03610	SLEEP LAB	0	0	5	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,048	0	943	9,181	0	90.00
91.00	09100	EMERGENCY	144,433	0	3,960	792	59,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	286	7	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,322,532	1,801,536	458,300	482,957	1,565,899	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,436	0	80	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,325,968	1,801,536	458,380	482,957	1,565,899	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I Date/Time Prepared: 9/28/2016 9:11 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,157,366	0	13,157,366		30.00
31.00	03100	INTENSIVE CARE UNIT	2,652,028	0	2,652,028		31.00
43.00	04300	NURSERY	634,687	0	634,687		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,364,720	0	6,364,720		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,351,263	0	1,351,263		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,903,557	0	3,903,557		54.00
56.00	05600	RADIOISOTOPE	649,994	0	649,994		56.00
57.00	05700	CT SCAN	698,793	0	698,793		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	438,989	0	438,989		58.00
59.00	05900	CARDIAC CATHETERIZATION	427,901	0	427,901		59.00
60.00	06000	LABORATORY	3,831,312	0	3,831,312		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	623,203	0	623,203		63.00
65.00	06500	RESPIRATORY THERAPY	818,718	0	818,718		65.00
66.00	06600	PHYSICAL THERAPY	1,229,272	0	1,229,272		66.00
67.00	06700	OCCUPATIONAL THERAPY	125,256	0	125,256		67.00
68.00	06800	SPEECH PATHOLOGY	141,865	0	141,865		68.00
69.00	06900	ELECTROCARDIOLOGY	1,003,454	0	1,003,454		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,177,684	0	5,177,684		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,241,518	0	3,241,518		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,632,626	0	4,632,626		73.00
76.00	03610	SLEEP LAB	26,412	0	26,412		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	2,302,495	0	2,302,495		90.00
91.00	09100	EMERGENCY	8,850,396	0	8,850,396		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,151,177	0	1,151,177		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,434,686	0	63,434,686		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	177,255	0	177,255		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	663,701	0	663,701		192.00
194.00	07950	VACANT SPACE	35,064	0	35,064		194.00
194.01	07951	LEASED SPACE	180,403	0	180,403		194.01
194.02	07952	FOUNDATION	17,638	0	17,638		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	64,508,747	0	64,508,747		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/28/2016 9:11 am

		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	8,800	702	9,502	9,502	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,724	582,568	921,816	1,538,108	1,951	5.00
7.00	00700	OPERATION OF PLANT	7,050	296,165	23,381	326,596	191	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,309	22,116	44,425	70	8.00
9.00	00900	HOUSEKEEPING	0	1,772	5,099	6,871	238	9.00
10.00	01000	DIETARY	0	42,472	5,691	48,163	53	10.00
11.00	01100	CAFETERIA	0	11,880	20,085	31,965	241	11.00
13.00	01300	NURSING ADMINISTRATION	0	57,355	41,844	99,199	286	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,471	30,919	60,671	123,061	39	14.00
15.00	01500	PHARMACY	176,263	10,227	10,211	196,701	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,556	2,674	28,230	234	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,976	246,237	97,179	368,392	1,663	30.00
31.00	03100	INTENSIVE CARE UNIT	7,498	23,701	49,812	81,011	426	31.00
43.00	04300	NURSERY	0	6,160	6,203	12,363	84	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	123,868	298,462	422,330	915	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	19,979	18,107	38,086	246	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,307	93,067	267,567	399,941	506	54.00
56.00	05600	RADIOISOTOPE	0	5,203	2,405	7,608	53	56.00
57.00	05700	CT SCAN	0	4,578	5,819	10,397	74	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,935	12,082	372	17,389	66	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,549	26,762	31,311	61	59.00
60.00	06000	LABORATORY	0	35,789	52,025	87,814	408	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	911	911	22	63.00
65.00	06500	RESPIRATORY THERAPY	14,947	9,074	21,092	45,113	146	65.00
66.00	06600	PHYSICAL THERAPY	0	23,487	2,000	25,487	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,854	58	2,912	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,988	0	10,988	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,669	48,240	79,909	147	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	276	73.00
76.00	03610	SLEEP LAB	0	4,400	0	4,400	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	12,017	4,985	17,002	169	90.00
91.00	09100	EMERGENCY	87	87,484	30,177	117,748	796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	14,053	0	8,562	22,615	134	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	354,311	1,847,209	2,055,028	4,256,548	9,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,713	68	23,781	7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	108,735	0	108,735	0	192.00
194.00	07950	VACANT SPACE	0	5,863	0	5,863	0	194.00
194.01	07951	LEASED SPACE	0	30,164	0	30,164	0	194.01
194.02	07952	FOUNDATION	0	2,949	0	2,949	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	354,311	2,018,633	2,055,096	4,428,040	9,502	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II Date/Time Prepared: 9/28/2016 9:11 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,540,059					5.00
7.00	00700	OPERATION OF PLANT	87,872	414,659				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,946	8,179	64,620			8.00
9.00	00900	HOUSEKEEPING	35,792	650	4,140	47,691		9.00
10.00	01000	DIETARY	11,901	15,570	81	1,830	77,598	10.00
11.00	01100	CAFETERIA	30,337	4,355	0	512	0	11.00
13.00	01300	NURSING ADMINISTRATION	35,586	21,026	0	2,471	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,027	11,335	5,532	1,332	0	14.00
15.00	01500	PHARMACY	10,338	3,749	0	441	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,957	9,369	0	1,101	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	202,005	90,273	14,300	10,607	70,261	30.00
31.00	03100	INTENSIVE CARE UNIT	50,090	8,689	8,597	1,021	7,337	31.00
43.00	04300	NURSERY	9,692	2,258	961	265	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	123,461	45,410	9,891	5,336	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,395	7,324	2,804	861	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,187	34,118	4,652	4,009	0	54.00
56.00	05600	RADIOISOTOPE	14,758	1,907	0	224	0	56.00
57.00	05700	CT SCAN	15,832	1,678	0	197	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,634	4,429	262	521	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,497	1,668	0	196	0	59.00
60.00	06000	LABORATORY	85,241	13,120	45	1,542	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	14,758	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	17,756	3,326	0	391	0	65.00
66.00	06600	PHYSICAL THERAPY	23,479	8,610	927	1,012	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,674	1,046	0	123	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,168	4,028	0	473	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,717	11,610	113	1,364	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,233	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,394	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,737	0	0	0	0	73.00
76.00	03610	SLEEP LAB	142	1,613	0	190	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	52,437	4,405	0	518	0	90.00
91.00	09100	EMERGENCY	194,319	32,071	10,805	3,769	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	27,475	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,533,837	351,816	63,110	40,306	77,598	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,517	8,693	0	1,022	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,463	39,862	1,510	4,684	0	192.00
194.00	07950	VACANT SPACE	187	2,149	0	253	0	194.00
194.01	07951	LEASED SPACE	961	11,058	0	1,299	0	194.01
194.02	07952	FOUNDATION	94	1,081	0	127	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,540,059	414,659	64,620	47,691	77,598	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/28/2016 9:11 am

		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	67,410					11.00
13.00	01300	NURSING ADMINISTRATION	2,257	160,825				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	671	0	147,997			14.00
15.00	01500	PHARMACY	92	0	190	211,511		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,345	0	278	0	75,514	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,773	134,841	1,196	258	44,876	30.00
31.00	03100	INTENSIVE CARE UNIT	3,741	16,314	35	1	2,181	31.00
43.00	04300	NURSERY	761	9,670	49	3	3,286	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,106	0	2,752	3,336	16,139	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,221	0	143	8	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,576	0	381	875	0	54.00
56.00	05600	RADIOISOTOPE	384	0	17	24	0	56.00
57.00	05700	CT SCAN	727	0	10	1	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	705	0	42	2,125	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	440	0	9	130	0	59.00
60.00	06000	LABORATORY	4,680	0	622	28	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	255	0	3	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,650	0	97	16	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	126	0	6,173	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	1,472	0	137	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	86,228	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	53,979	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,000	0	0	200,335	0	73.00
76.00	03610	SLEEP LAB	0	0	2	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,036	0	304	4,021	0	90.00
91.00	09100	EMERGENCY	7,343	0	1,279	347	2,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	92	3	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,235	160,825	147,971	211,511	75,514	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	175	0	26	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	67,410	160,825	147,997	211,511	75,514	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/28/2016 9:11 am

		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	956,445	0	956,445		30.00
31.00	03100	INTENSIVE CARE UNIT	179,443	0	179,443		31.00
43.00	04300	NURSERY	39,392	0	39,392		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	638,676	0	638,676		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	80,088	0	80,088		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529,245	0	529,245		54.00
56.00	05600	RADIOISOTOPE	24,975	0	24,975		56.00
57.00	05700	CT SCAN	28,916	0	28,916		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	34,173	0	34,173		58.00
59.00	05900	CARDIAC CATHETERIZATION	43,312	0	43,312		59.00
60.00	06000	LABORATORY	193,500	0	193,500		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,949	0	15,949		63.00
65.00	06500	RESPIRATORY THERAPY	68,495	0	68,495		65.00
66.00	06600	PHYSICAL THERAPY	65,814	0	65,814		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,755	0	6,755		67.00
68.00	06800	SPEECH PATHOLOGY	17,657	0	17,657		68.00
69.00	06900	ELECTROCARDIOLOGY	114,469	0	114,469		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,461	0	203,461		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	127,373	0	127,373		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,348	0	301,348		73.00
76.00	03610	SLEEP LAB	6,347	0	6,347		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	80,892	0	80,892		90.00
91.00	09100	EMERGENCY	371,336	0	371,336		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	50,319	0	50,319		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,178,380	0	4,178,380		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,221	0	35,221		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	158,254	0	158,254		192.00
194.00	07950	VACANT SPACE	8,452	0	8,452		194.00
194.01	07951	LEASED SPACE	43,482	0	43,482		194.01
194.02	07952	FOUNDATION	4,251	0	4,251		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,428,040	0	4,428,040		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/28/2016 9:11 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	339,493					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,013,117				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,480	688	25,480,104			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	97,976	902,989	5,233,841	-16,146,796	48,361,951	5.00
7.00	00700	OPERATION OF PLANT	49,809	22,903	510,730	0	2,759,455	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	21,664	187,414	0	375,133	8.00
9.00	00900	HOUSEKEEPING	298	4,995	639,284	0	1,123,980	9.00
10.00	01000	DIETARY	7,143	5,575	141,126	0	373,721	10.00
11.00	01100	CAFETERIA	1,998	19,675	646,241	0	952,686	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	40,989	766,711	0	1,117,514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	59,432	105,565	0	189,266	14.00
15.00	01500	PHARMACY	1,720	10,002	0	0	324,640	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	2,619	627,232	0	1,034,945	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	95,194	4,459,197	0	6,342,938	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	48,794	1,141,571	0	1,572,968	31.00
43.00	04300	NURSERY	1,036	6,076	226,206	0	304,347	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	292,365	2,454,253	0	3,877,056	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	17,737	660,278	0	891,701	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	262,101	1,357,563	0	2,486,728	54.00
56.00	05600	RADIOISOTOPE	875	2,356	142,005	0	463,436	56.00
57.00	05700	CT SCAN	770	5,700	197,725	0	497,189	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	364	177,215	0	271,147	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	26,215	163,755	0	298,223	59.00
60.00	06000	LABORATORY	6,019	50,962	1,093,252	0	2,676,826	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	892	59,611	0	463,444	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	20,661	390,899	0	557,588	65.00
66.00	06600	PHYSICAL THERAPY	3,950	1,959	0	0	737,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	57	0	0	83,961	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	0	0	68,076	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	47,255	393,945	0	619,190	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,681,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,304,814	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	740,667	0	3,100,633	73.00
76.00	03610	SLEEP LAB	740	0	0	0	4,469	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	4,883	452,463	0	1,646,694	90.00
91.00	09100	EMERGENCY	14,713	29,561	2,132,903	0	6,102,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,387	360,238	0	862,813	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,663	2,013,050	25,461,890	-16,146,796	48,166,597	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	67	18,214	0	47,643	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	0	0	108,735	192.00
194.00	07950	VACANT SPACE	986	0	0	0	5,863	194.00
194.01	07951	LEASED SPACE	5,073	0	0	0	30,164	194.01
194.02	07952	FOUNDATION	496	0	0	0	2,949	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,018,633	2,055,096	6,351,333		16,146,796	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.946022	1.020853	0.249266		0.333874	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,502		1,540,059	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000373		0.031844	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/28/2016 9:11 am

		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	190,228					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	708,280				8.00
9.00	00900	HOUSEKEEPING	298	45,381	186,178			9.00
10.00	01000	DIETARY	7,143	893	7,143	50,044		10.00
11.00	01100	CAFETERIA	1,998	0	1,998	0	33,573	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	0	9,646	0	1,124	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	60,639	5,200	0	334	14.00
15.00	01500	PHARMACY	1,720	0	1,720	0	46	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	0	4,298	0	1,666	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	156,726	41,412	45,312	8,853	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	94,225	3,986	4,732	1,863	31.00
43.00	04300	NURSERY	1,036	10,529	1,036	0	379	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	108,407	20,832	0	4,535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	30,738	3,360	0	1,106	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	50,991	15,652	0	2,777	54.00
56.00	05600	RADIOISOTOPE	875	0	875	0	191	56.00
57.00	05700	CT SCAN	770	0	770	0	362	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	2,873	2,032	0	351	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	0	765	0	219	59.00
60.00	06000	LABORATORY	6,019	498	6,019	0	2,331	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	127	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	0	1,526	0	822	65.00
66.00	06600	PHYSICAL THERAPY	3,950	10,163	3,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	0	480	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	1,848	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	1,238	5,326	0	733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	996	73.00
76.00	03610	SLEEP LAB	740	0	740	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	0	2,021	0	1,014	90.00
91.00	09100	EMERGENCY	14,713	118,427	14,713	0	3,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	161,398	691,728	157,348	50,044	33,486	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	3,988	0	87	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	16,552	18,287	0	0	192.00
194.00	07950	VACANT SPACE	986	0	986	0	0	194.00
194.01	07951	LEASED SPACE	5,073	0	5,073	0	0	194.01
194.02	07952	FOUNDATION	496	0	496	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,680,765	572,978	1,541,726	696,582	1,325,968	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.349228	0.808971	8.280925	13.919391	39.495070	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	414,659	64,620	47,691	77,598	67,410	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.179800	0.091235	0.256158	1.550595	2.007863	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/28/2016 9:11 am

		Cost Center Description	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,338					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,319,156				14.00
15.00	01500	PHARMACY	0	8,099	2,251,514			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,856	0	29,051		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,183	51,058	2,749	17,264		30.00
31.00	03100	INTENSIVE CARE UNIT	1,353	1,508	10	839		31.00
43.00	04300	NURSERY	802	2,088	31	1,264		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	117,509	35,510	6,209		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,097	89	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,277	9,318	0		54.00
56.00	05600	RADIOISOTOPE	0	718	259	0		56.00
57.00	05700	CT SCAN	0	422	12	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,780	22,619	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	376	1,379	0		59.00
60.00	06000	LABORATORY	0	26,547	301	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	149	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	4,150	167	0		65.00
66.00	06600	PHYSICAL THERAPY	0	5,391	0	2,375		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,831	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,681,768	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,304,814	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,132,545	0		73.00
76.00	03610	SLEEP LAB	0	69	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	12,999	42,799	0		90.00
91.00	09100	EMERGENCY	0	54,593	3,694	1,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,949	32	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,338	6,318,048	2,251,514	29,051		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,108	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	VACANT SPACE	0	0	0	0		194.00
194.01	07951	LEASED SPACE	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,801,536	458,380	482,957	1,565,899		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	135.067926	0.072538	0.214503	53.901725		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	160,825	147,997	211,511	75,514		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.057655	0.023420	0.093942	2.599360		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/28/2016 9:11 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,157,366		13,157,366	0	13,157,366	30.00
31.00	03100	INTENSIVE CARE UNIT	2,652,028		2,652,028	0	2,652,028	31.00
43.00	04300	NURSERY	634,687		634,687	0	634,687	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,364,720		6,364,720	0	6,364,720	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,351,263		1,351,263	0	1,351,263	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,903,557		3,903,557	0	3,903,557	54.00
56.00	05600	RADIOISOTOPE	649,994		649,994	0	649,994	56.00
57.00	05700	CT SCAN	698,793		698,793	0	698,793	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	438,989		438,989	0	438,989	58.00
59.00	05900	CARDIAC CATHETERIZATION	427,901		427,901	0	427,901	59.00
60.00	06000	LABORATORY	3,831,312		3,831,312	0	3,831,312	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	623,203		623,203	0	623,203	63.00
65.00	06500	RESPIRATORY THERAPY	818,718	0	818,718	0	818,718	65.00
66.00	06600	PHYSICAL THERAPY	1,229,272	0	1,229,272	0	1,229,272	66.00
67.00	06700	OCCUPATIONAL THERAPY	125,256	0	125,256	0	125,256	67.00
68.00	06800	SPEECH PATHOLOGY	141,865	0	141,865	0	141,865	68.00
69.00	06900	ELECTROCARDIOLOGY	1,003,454		1,003,454	3,110	1,006,564	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,177,684		5,177,684	0	5,177,684	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,241,518		3,241,518	0	3,241,518	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,632,626		4,632,626	0	4,632,626	73.00
76.00	03610	SLEEP LAB	26,412		26,412	0	26,412	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,302,495		2,302,495	0	2,302,495	90.00
91.00	09100	EMERGENCY	8,850,396		8,850,396	0	8,850,396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,463,910		1,463,910		1,463,910	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,151,177		1,151,177		1,151,177	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	64,898,596	0	64,898,596	3,110	64,901,706	200.00
201.00		Less Observation Beds	1,463,910		1,463,910		1,463,910	201.00
202.00		Total (see instructions)	63,434,686	0	63,434,686	3,110	63,437,796	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/28/2016 9:11 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,327,040		19,327,040			30.00
31.00	03100	INTENSIVE CARE UNIT	3,557,645		3,557,645			31.00
43.00	04300	NURSERY	779,665		779,665			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,143,422	35,497,917	45,641,339	0.139451	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,980,422	295,436	2,275,858	0.593738	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,215,036	14,613,102	17,828,138	0.218955	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,125,714	4,691,534	5,817,248	0.111736	0.000000	56.00
57.00	05700	CT SCAN	4,647,935	22,648,622	27,296,557	0.025600	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	507,708	6,240,145	6,747,853	0.065056	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,134,703	1,324,852	2,459,555	0.173975	0.000000	59.00
60.00	06000	LABORATORY	4,613,941	10,229,275	14,843,216	0.258119	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	569,735	239,687	809,422	0.769936	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	3,007,197	251,334	3,258,531	0.251254	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,532,551	1,697,476	3,230,027	0.380576	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,999	185,097	447,096	0.280155	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	137,315	138,030	275,345	0.515226	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,131,032	6,888,768	10,019,800	0.100147	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,579,702	3,450,903	10,030,605	0.516189	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,950,337	1,638,726	6,589,063	0.491954	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,310,946	10,843,711	23,154,657	0.200073	0.000000	73.00
76.00	03610	SLEEP LAB	0	1,354,404	1,354,404	0.019501	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,754	4,074,511	4,095,265	0.562233	0.000000	90.00
91.00	09100	EMERGENCY	4,747,171	25,268,833	30,016,004	0.294856	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	267,665	1,958,165	2,225,830	0.657692	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,756,176	1,756,176			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	88,549,635	155,286,704	243,836,339			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	88,549,635	155,286,704	243,836,339			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/28/2016 9:11 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.139451		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.593738		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218955		54.00
56.00	05600	RADIOISOTOPE	0.111736		56.00
57.00	05700	CT SCAN	0.025600		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.065056		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.173975		59.00
60.00	06000	LABORATORY	0.258119		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.769936		63.00
65.00	06500	RESPIRATORY THERAPY	0.251254		65.00
66.00	06600	PHYSICAL THERAPY	0.380576		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280155		67.00
68.00	06800	SPEECH PATHOLOGY	0.515226		68.00
69.00	06900	ELECTROCARDIOLOGY	0.100457		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.516189		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.491954		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200073		73.00
76.00	03610	SLEEP LAB	0.019501		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.562233		90.00
91.00	09100	EMERGENCY	0.294856		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.657692		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part I Date/Time Prepared: 9/28/2016 9:11 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	956,445	0	956,445	12,583	76.01	30.00
31.00	INTENSIVE CARE UNIT	179,443		179,443	1,353	132.63	31.00
43.00	NURSERY	39,392		39,392	802	49.12	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,175,280		1,175,280	14,738		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	5,751	437,134				30.00
31.00	INTENSIVE CARE UNIT	559	74,140				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30-199)	6,310	511,274				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part II Date/Time Prepared: 9/28/2016 9:11 am

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	638,676	45,641,339	0.013993	5,048,573	70,645	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	80,088	2,275,858	0.035190	5,739	202	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	529,245	17,828,138	0.029686	1,759,251	52,225	54.00
56.00	05600	RADIOISOTOPE	24,975	5,817,248	0.004293	680,918	2,923	56.00
57.00	05700	CT SCAN	28,916	27,296,557	0.001059	2,378,660	2,519	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	34,173	6,747,853	0.005064	207,190	1,049	58.00
59.00	05900	CARDIAC CATHETERIZATION	43,312	2,459,555	0.017610	792,721	13,960	59.00
60.00	06000	LABORATORY	193,500	14,843,216	0.013036	2,342,635	30,539	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,949	809,422	0.019704	329,811	6,499	63.00
65.00	06500	RESPIRATORY THERAPY	68,495	3,258,531	0.021020	1,673,804	35,183	65.00
66.00	06600	PHYSICAL THERAPY	65,814	3,230,027	0.020376	938,260	19,118	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,755	447,096	0.015109	155,887	2,355	67.00
68.00	06800	SPEECH PATHOLOGY	17,657	275,345	0.064127	105,432	6,761	68.00
69.00	06900	ELECTROCARDIOLOGY	114,469	10,019,800	0.011424	1,801,856	20,584	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,461	10,030,605	0.020284	3,518,153	71,362	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	127,373	6,589,063	0.019331	2,958,779	57,196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,348	23,154,657	0.013015	5,935,818	77,255	73.00
76.00	03610	SLEEP LAB	6,347	1,354,404	0.004686	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	80,892	4,095,265	0.019753	20,754	410	90.00
91.00	09100	EMERGENCY	371,336	30,016,004	0.012371	2,506,743	31,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	106,416	2,225,830	0.047810	189,421	9,056	92.00
200.00		Total (lines 50-199)	3,059,197	218,415,813		33,350,405	510,852	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part III Date/Time Prepared: 9/28/2016 9:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
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	12,583	0.00	5,751	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,353	0.00	559	0		31.00
43.00	04300	NURSERY	802	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	14,738		6,310	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/28/2016 9:11 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/28/2016 9:11 am

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	45,641,339	0.000000	0.000000	5,048,573	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,275,858	0.000000	0.000000	5,739	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,828,138	0.000000	0.000000	1,759,251	54.00
56.00	05600	RADIOISOTOPE	0	5,817,248	0.000000	0.000000	680,918	56.00
57.00	05700	CT SCAN	0	27,296,557	0.000000	0.000000	2,378,660	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,747,853	0.000000	0.000000	207,190	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,459,555	0.000000	0.000000	792,721	59.00
60.00	06000	LABORATORY	0	14,843,216	0.000000	0.000000	2,342,635	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	809,422	0.000000	0.000000	329,811	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,258,531	0.000000	0.000000	1,673,804	65.00
66.00	06600	PHYSICAL THERAPY	0	3,230,027	0.000000	0.000000	938,260	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	447,096	0.000000	0.000000	155,887	67.00
68.00	06800	SPEECH PATHOLOGY	0	275,345	0.000000	0.000000	105,432	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,019,800	0.000000	0.000000	1,801,856	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,030,605	0.000000	0.000000	3,518,153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,589,063	0.000000	0.000000	2,958,779	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,154,657	0.000000	0.000000	5,935,818	73.00
76.00	03610	SLEEP LAB	0	1,354,404	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,095,265	0.000000	0.000000	20,754	90.00
91.00	09100	EMERGENCY	0	30,016,004	0.000000	0.000000	2,506,743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,225,830	0.000000	0.000000	189,421	92.00
200.00		Total (lines 50-199)	0	218,415,813			33,350,405	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/28/2016 9:11 am

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	7,841,210	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,479,818	0		54.00
56.00	05600	RADIOISOTOPE	0	1,827,713	0		56.00
57.00	05700	CT SCAN	0	7,462,862	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,760,882	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	728,975	0		59.00
60.00	06000	LABORATORY	0	1,386,928	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	155,108	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	89,790	0		65.00
66.00	06600	PHYSICAL THERAPY	0	4,677	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	438	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	372	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,661,982	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	792,255	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	642,634	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,207,799	0		73.00
76.00	03610	SLEEP LAB	0	384,120	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	920,206	0		90.00
91.00	09100	EMERGENCY	0	4,204,212	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	624,492	0		92.00
200.00		Total (lines 50-199)	0	38,176,473	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/28/2016 9:11 am

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	0.139451	7,841,210	0	0	1,093,465	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.593738	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218955	3,479,818	0	0	761,924	54.00
56.00	05600	RADIOISOTOPE	0.111736	1,827,713	0	0	204,221	56.00
57.00	05700	CT SCAN	0.025600	7,462,862	0	0	191,049	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.065056	1,760,882	0	0	114,556	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.173975	728,975	0	0	126,823	59.00
60.00	06000	LABORATORY	0.258119	1,386,928	1,116	0	357,992	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.769936	155,108	0	0	119,423	63.00
65.00	06500	RESPIRATORY THERAPY	0.251254	89,790	0	0	22,560	65.00
66.00	06600	PHYSICAL THERAPY	0.380576	4,677	0	0	1,780	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280155	438	0	0	123	67.00
68.00	06800	SPEECH PATHOLOGY	0.515226	372	0	0	192	68.00
69.00	06900	ELECTROCARDIOLOGY	0.100147	2,661,982	0	0	266,590	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.516189	792,255	0	0	408,953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.491954	642,634	30,500	0	316,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200073	3,207,799	0	0	641,794	73.00
76.00	03610	SLEEP LAB	0.019501	384,120	0	0	7,491	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.562233	920,206	0	0	517,370	90.00
91.00	09100	EMERGENCY	0.294856	4,204,212	0	0	1,239,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.657692	624,492	0	0	410,723	92.00
200.00		Subtotal (see instructions)		38,176,473	31,616	0	6,802,812	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		38,176,473	31,616	0	6,802,812	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/28/2016 9:11 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	288	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,005	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03610	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	15,293	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	15,293	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Prepared: 9/28/2016 9:11 am
	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)	12,583	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,583	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)	11,183	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,751	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	13,157,366	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	13,157,366	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	13,157,366	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)	1,045.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,013,533	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	6,013,533	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/28/2016 9:11 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,652,028	1,353	1,960.11	559	1,095,701	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)	8,630,837	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,740,071	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	511,274	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	510,852	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,022,126	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,717,945	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,400	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,045.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,463,910	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/28/2016 9:11 am

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	956,445	13,157,366	0.072693	1,463,910	106,416	90.00
91.00	Nursing School cost	0	13,157,366	0.000000	1,463,910	0	91.00
92.00	Allied health cost	0	13,157,366	0.000000	1,463,910	0	92.00
93.00	All other Medical Education	0	13,157,366	0.000000	1,463,910	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-3 | Date/Time Prepared: 9/28/2016 9:11 am

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		9,357,927		30.00
31.00	03100	INTENSIVE CARE UNIT		1,587,296		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.139451	5,048,573	704,029	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.593738	5,739	3,407	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218955	1,759,251	385,197	54.00
56.00	05600	RADIOISOTOPE	0.111736	680,918	76,083	56.00
57.00	05700	CT SCAN	0.025600	2,378,660	60,894	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.065056	207,190	13,479	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.173975	792,721	137,914	59.00
60.00	06000	LABORATORY	0.258119	2,342,635	604,679	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.769936	329,811	253,933	63.00
65.00	06500	RESPIRATORY THERAPY	0.251254	1,673,804	420,550	65.00
66.00	06600	PHYSICAL THERAPY	0.380576	938,260	357,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280155	155,887	43,673	67.00
68.00	06800	SPEECH PATHOLOGY	0.515226	105,432	54,321	68.00
69.00	06900	ELECTROCARDIOLOGY	0.100457	1,801,856	181,009	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.516189	3,518,153	1,816,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.491954	2,958,779	1,455,583	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200073	5,935,818	1,187,597	73.00
76.00	03610	SLEEP LAB	0.019501	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.562233	20,754	11,669	90.00
91.00	09100	EMERGENCY	0.294856	2,506,743	739,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.657692	189,421	124,581	92.00
200.00		Total (sum of lines 50-94 and 96-98)		33,350,405	8,630,837	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)		33,350,405		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/28/2016 9:11 am
	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)	8,993,033	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	168,849	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)	103.17	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)	2.23	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.56	31.00
32.00	Sum of lines 30 and 31	20.79	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.37	33.00
34.00	Disproportionate share adjustment (see instructions)	143,214	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/28/2016 9:11 am
	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)	0.000079184	0.000080423	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	605,571	515,199	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	253,842	299,829	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	553,671		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)	9,858,767		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	9,858,767	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	757,507	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)	10,616,274	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	10,616,274	61.00
62.00	Deductibles billed to program beneficiaries	1,250,816	62.00
63.00	Coinsurance billed to program beneficiaries	35,098	63.00
64.00	Allowable bad debts (see instructions)	150,175	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	97,614	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	96,194	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,427,974	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	22,670	70.93
70.94	HRR adjustment amount (see instructions)	-255,956	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/28/2016 9:11 am
	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)		9,194,688	71.00
71.01	Sequestration adjustment (see instructions)		183,894	71.01
72.00	Interim payments		8,938,418	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)		72,376	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35,363	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prepared: 9/28/2016 9:11 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,293	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,802,812	2.00
3.00	PPS payments	5,424,317	3.00
4.00	Outlier payment (see instructions)	4,182	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)	15,293	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	31,616	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)	31,616	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)	31,616	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	16,323	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)	15,293	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,428,499	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	6,100	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,203,513	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)	4,234,179	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,234,179	30.00
31.00	Primary payer payments	732	31.00
32.00	Subtotal (line 30 minus line 31)	4,233,447	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)	174,831	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	113,640	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	126,824	36.00
37.00	Subtotal (see instructions)	4,347,087	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,347,087	40.00
40.01	Sequestration adjustment (see instructions)	86,942	40.01
41.00	Interim payments	4,261,071	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-926	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 9/28/2016 9:11 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,951,757		4,295,080	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	12/08/2015	13,339	12/08/2015	34,009	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)		-13,339		-34,009	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)		8,938,418		4,261,071	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		72,376		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		926	6.02
7.00	Total Medicare program liability (see instructions)		9,010,794		4,260,145	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet E-1 Part II Date/Time Prepared: 9/28/2016 9:11 am
	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	3,198	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	6,310	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,223	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	12,536	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	243,836,339	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,073,244	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)	411,895	8.00
9.00	Sequestration adjustment amount (see instructions)	8,238	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	403,657	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	418,015	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)	-14,358	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G | Date/Time Prepared: 9/28/2016 9:11 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,105,525	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	17,613,782	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,441,000	0	0	0	6.00
7.00	Inventory	1,046,755	0	0	0	7.00
8.00	Prepaid expenses	2,069,528	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,394,590	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,449,581	0	0	0	12.00
13.00	Land improvements	1,827,216	0	0	0	13.00
14.00	Accumulated depreciation	-1,747,095	0	0	0	14.00
15.00	Buildings	11,585,946	0	0	0	15.00
16.00	Accumulated depreciation	-9,206,490	0	0	0	16.00
17.00	Leasehold improvements	20,362,006	0	0	0	17.00
18.00	Accumulated depreciation	-15,326,991	0	0	0	18.00
19.00	Fixed equipment	19,114,647	0	0	0	19.00
20.00	Accumulated depreciation	-13,291,983	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	32,126,586	0	0	0	23.00
24.00	Accumulated depreciation	-24,683,611	0	0	0	24.00
25.00	Minor equipment depreciable	1,249,342	0	0	0	25.00
26.00	Accumulated depreciation	-1,107,494	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	2,378,511	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,730,171	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	13,795,895	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	440,394	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,236,289	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	55,361,050	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,972,809	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,905,177	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	3,573,500	0	0	0	43.00
44.00	Other current liabilities	2,796,855	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,248,341	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,118,808	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,074,510	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	17,193,318	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,441,659	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,919,391				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	23,919,391	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55,361,050	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-1 | Date/Time Prepared: 9/28/2016 9:11 am

		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		37,919,764		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-7,492,413				2.00
3.00	Total (sum of line 1 and line 2)		30,427,351		0		3.00
4.00	CHANGE IN RESTRICTED ASSETS	41,235		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)		41,235		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,468,586		0		11.00
12.00	TRANSFER TO AFFILIATES	5,528,999		0		0	12.00
13.00	MINIMUM PENSION LIABILITY	1,020,196		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)		6,549,195		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,919,391		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	CHANGE IN RESTRICTED ASSETS		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	TRANSFER TO AFFILIATES		0		12.00
13.00	MINIMUM PENSION LIABILITY		0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/28/2016 9:11 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,298,734		22,298,734	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,298,734		22,298,734	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,568,997		3,568,997	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,568,997		3,568,997	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,867,731		25,867,731	17.00
18.00	Ancillary services	59,063,130	123,604,849	182,667,979	18.00
19.00	Outpatient services	5,031,745	31,671,534	36,703,279	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,756,176	1,756,176	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	1,145,936	13,748,154	14,894,090	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	91,108,542	170,780,713	261,889,255	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		73,909,683		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)		73,909,683		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140120 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-3 | Date/Time Prepared: 9/28/2016 9:11 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	261,889,255	1.00
2.00	Less contractual allowances and discounts on patients' accounts	196,073,687	2.00
3.00	Net patient revenues (line 1 minus line 2)	65,815,568	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	73,909,683	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,094,115	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	152,744	6.00
7.00	Income from investments	2,166,251	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	72,060	13.00
14.00	Revenue from meals sold to employees and guests	570,069	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	28,912	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	581	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	44,707	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED LOSS ON INVESTMENTS	-2,743,937	24.00
24.01	WELLNESS CENTER	16,253	24.01
24.02	INVESTMENT INCOME ON SI TRUST	32,900	24.02
24.03	MISCELLANEOUS INCOME	85,930	24.03
24.04	EHR FUNDS	175,010	24.04
25.00	Total other income (sum of lines 6-24)	601,480	25.00
26.00	Total (line 5 plus line 25)	-7,492,635	26.00
27.00	GAIN/LOSS ON ASSET DISPOSAL	-222	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-222	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-7,492,413	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H | Date/Time Prepared: 9/28/2016 9:11 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		14,053	14,053	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	5,524	5,524	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	110,493	0	18,240	4,058	44,334	177,125	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	246,429	0	0	0	0	246,429	6.00
7.00	Physical Therapy	0	0	0	231,410	0	231,410	7.00
8.00	Occupational Therapy	0	0	0	80,962	0	80,962	8.00
9.00	Speech Pathology	0	0	0	3,447	0	3,447	9.00
10.00	Medical Social Services	189	0	0	0	0	189	10.00
11.00	Home Health Aide	3,127	0	0	0	0	3,127	11.00
12.00	Supplies (see instructions)	0	0	0	3,600	6,993	10,593	12.00
13.00	Drugs	0	0	0	0	32	32	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	360,238	0	18,240	323,477	70,936	772,891	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	14,053	0	14,053			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	5,524	0	5,524			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	128	177,253	-1,581	175,672			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	246,429	0	246,429			6.00
7.00	Physical Therapy	0	231,410	0	231,410			7.00
8.00	Occupational Therapy	0	80,962	0	80,962			8.00
9.00	Speech Pathology	0	3,447	0	3,447			9.00
10.00	Medical Social Services	0	189	0	189			10.00
11.00	Home Health Aide	0	3,127	0	3,127			11.00
12.00	Supplies (see instructions)	-6,993	3,600	0	3,600			12.00
13.00	Drugs	11	43	0	43			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-6,854	766,037	-1,581	764,456			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-1 Part I | Date/Time Prepared: 9/28/2016 9:11 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	14,053	14,053				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	5,524	0	0	5,524		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	175,672	14,053	0	5,524	0	195,249	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	246,429	0	0	0	0	246,429	6.00
7.00	Physical Therapy	231,410	0	0	0	0	231,410	7.00
8.00	Occupational Therapy	80,962	0	0	0	0	80,962	8.00
9.00	Speech Pathology	3,447	0	0	0	0	3,447	9.00
10.00	Medical Social Services	189	0	0	0	0	189	10.00
11.00	Home Health Aide	3,127	0	0	0	0	3,127	11.00
12.00	Supplies (see instructions)	3,600	0	0	0	0	3,600	12.00
13.00	Drugs	43	0	0	0		43	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	764,456	14,053	0	5,524	0	764,456	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	195,249		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	84,529	330,958	6.00
7.00	Physical Therapy	79,378	310,788	7.00
8.00	Occupational Therapy	27,772	108,734	8.00
9.00	Speech Pathology	1,182	4,629	9.00
10.00	Medical Social Services	65	254	10.00
11.00	Home Health Aide	1,073	4,200	11.00
12.00	Supplies (see instructions)	1,235	4,835	12.00
13.00	Drugs	15	58	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		764,456	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-1 Part II | Date/Time Prepared: 9/28/2016 9:11 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,000				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	2,000		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	2,000	0	2,000	0	-195,249	569,207	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	246,429	6.00
7.00	Physical Therapy	0	0	0	0	0	231,410	7.00
8.00	Occupational Therapy	0	0	0	0	0	80,962	8.00
9.00	Speech Pathology	0	0	0	0	0	3,447	9.00
10.00	Medical Social Services	0	0	0	0	0	189	10.00
11.00	Home Health Aide	0	0	0	0	0	3,127	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	3,600	12.00
13.00	Drugs	0	0	0		0	43	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,000	0	2,000	0	-195,249	569,207	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	14,053	0	5,524	0		195,249	25.00
26.00	Unit Cost Multiplier	7.026500	0.000000	2.762000	0.000000		0.343019	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-2 Part I Date/Time Prepared: 9/28/2016 9:11 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	8,562	27,542	36,104	12,054	1.00
2.00	Skilled Nursing Care	330,958	0	0	61,427	392,385	131,009	2.00
3.00	Physical Therapy	310,788	0	0	0	310,788	103,764	3.00
4.00	Occupational Therapy	108,734	0	0	0	108,734	36,303	4.00
5.00	Speech Pathology	4,629	0	0	0	4,629	1,546	5.00
6.00	Medical Social Services	254	0	0	47	301	100	6.00
7.00	Home Health Aide	4,200	0	0	779	4,979	1,662	7.00
8.00	Supplies (see instructions)	4,835	0	0	0	4,835	1,614	8.00
9.00	Drugs	58	0	0	0	58	19	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	764,456	0	8,562	89,795	862,813	288,071	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-2 Part I Date/Time Prepared: 9/28/2016 9:11 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	286	0	0	48,444	0	48,444	1.00
2.00	Skilled Nursing Care	0	0	0	523,394	0	523,394	2.00
3.00	Physical Therapy	0	0	0	414,552	0	414,552	3.00
4.00	Occupational Therapy	0	0	0	145,037	0	145,037	4.00
5.00	Speech Pathology	0	0	0	6,175	0	6,175	5.00
6.00	Medical Social Services	0	0	0	401	0	401	6.00
7.00	Home Health Aide	0	0	0	6,641	0	6,641	7.00
8.00	Supplies (see instructions)	0	0	0	6,449	0	6,449	8.00
9.00	Drugs	0	7	0	84	0	84	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	286	7	0	1,151,177	0	1,151,177	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	22,992	546,386	2.00
3.00	Physical Therapy	18,212	432,764	3.00
4.00	Occupational Therapy	6,372	151,409	4.00
5.00	Speech Pathology	271	6,446	5.00
6.00	Medical Social Services	18	419	6.00
7.00	Home Health Aide	292	6,933	7.00
8.00	Supplies (see instructions)	283	6,732	8.00
9.00	Drugs	4	88	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	48,444	1,151,177	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.043931		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-2 Part II Date/Time Prepared: 9/28/2016 9:11 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	8,387	110,493	0	36,104	0	1.00
2.00	Skilled Nursing Care	0	0	246,429	0	392,385	0	2.00
3.00	Physical Therapy	0	0	0	0	310,788	0	3.00
4.00	Occupational Therapy	0	0	0	0	108,734	0	4.00
5.00	Speech Pathology	0	0	0	0	4,629	0	5.00
6.00	Medical Social Services	0	0	189	0	301	0	6.00
7.00	Home Health Aide	0	0	3,127	0	4,979	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	4,835	0	8.00
9.00	Drugs	0	0	0	0	58	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	8,387	360,238		862,813	0	20.00
21.00	Total cost to be allocated	0	8,562	89,795		288,071	0	21.00
22.00	Unit cost multiplier	0.000000	1.020866	0.249266		0.333874	0.000000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	0	3,949	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	0	3,949	20.00
21.00	Total cost to be allocated	0	0	0	0	0	286	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.072423	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120 HHA CCN: 147057

Period: From 05/01/2015 To 04/30/2016

Worksheet H-2 Part II Date/Time Prepared: 9/28/2016 9:11 am

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	0	0			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	32	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
20.00	Total (sum of lines 1-19)	32	0			20.00
21.00	Total cost to be allocated	7	0			21.00
22.00	Unit cost multiplier	0.218750	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 9/28/2016 9:11 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	546,386		546,386	2,639	207.04	1.00
2.00	Physical Therapy	3.00	432,764	0	432,764	3,479	124.39	2.00
3.00	Occupational Therapy	4.00	151,409	0	151,409	1,222	123.90	3.00
4.00	Speech Pathology	5.00	6,446	0	6,446	35	184.17	4.00
5.00	Medical Social Services	6.00	419		419	2	209.50	5.00
6.00	Home Health Aide	7.00	6,933		6,933	221	31.37	6.00
7.00	Total (sum of lines 1-6)		1,144,357	0	1,144,357	7,598		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	0	1,063			8.00
8.01	Skilled Nursing Care		99914	0	85			8.01
9.00	Physical Therapy		37900	0	1,513			9.00
9.01	Physical Therapy		99914	0	156			9.01
10.00	Occupational Therapy		37900	0	616			10.00
10.01	Occupational Therapy		99914	0	14			10.01
11.00	Speech Pathology		37900	0	12			11.00
11.01	Speech Pathology		99914	0	4			11.01
12.00	Medical Social Services		37900	0	1			12.00
12.01	Medical Social Services		99914	0	0			12.01
13.00	Home Health Aide		37900	0	146			13.00
13.01	Home Health Aide		99914	0	1			13.01
14.00	Total (sum of lines 8-13)			0	3,611			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	6,732	0	6,732	5,445	1.236364	15.00
16.00	Cost of Drugs	9.00	88	0	88	188	0.468085	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,148		0	237,682		1.00
2.00	Physical Therapy	0	1,669		0	207,607		2.00
3.00	Occupational Therapy	0	630		0	78,057		3.00
4.00	Speech Pathology	0	16		0	2,947		4.00
5.00	Medical Social Services	0	1		0	210		5.00
6.00	Home Health Aide	0	147		0	4,611		6.00
7.00	Total (sum of lines 1-6)	0	3,611		0	531,114		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 9/28/2016 9:11 am

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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	5,445	0	0	6,732	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	237,682						1.00
2.00	Physical Therapy	207,607						2.00
3.00	Occupational Therapy	78,057						3.00
4.00	Speech Pathology	2,947						4.00
5.00	Medical Social Services	210						5.00
6.00	Home Health Aide	4,611						6.00
7.00	Total (sum of lines 1-6)	531,114						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-3 Part II Date/Time Prepared: 9/28/2016 9:11 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.380576	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.280155	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.515226	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.516189	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.200073	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140120 | HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 9/28/2016 9:11 am

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	669,043	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,154	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,074	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	683,271	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	683,271	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	683,271	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	683,271	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	683,271	31.00
31.01	Sequestration adjustment (see instructions)	0	13,666	31.01
32.00	Interim payments (see instructions)	0	669,605	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 140120 HHA CCN: 147057 | Period: From 05/01/2015 To 04/30/2016 | Worksheet H-5 Date/Time Prepared: 9/28/2016 9:11 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		669,605	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		669,605	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		669,605	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140120	Period: From 05/01/2015 To 04/30/2016	Worksheet L Parts I-III Date/Time Prepared: 9/28/2016 9:11 am
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	712,209	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	14,673	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)	34.87	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)	2.23	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	18.56	8.00
9.00	Sum of lines 7 and 8	20.79	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.30	10.00
11.00	Disproportionate share adjustment (see instructions)	30,625	11.00
12.00	Total prospective capital payments (see instructions)	757,507	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