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: 141312	Period: From 05/01/2015 To 04/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/19/2016 9:17 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/19/2016 Time: 9:17 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 ROCHELLE COMMUNITY HOSPITAL (141312) 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	718,440	-165,108	494,002	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	36,912	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	755,352	-165,108	494,002	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/15/2016 1:16 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 900 NORTH 2ND STREET	PO Box:			1.00
2.00	City: ROCHELLE	State: IL	Zip Code: 61068	County: OGLE	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	ROCHELLE COMMUNITY HOSPITAL	141312	99914	1	05/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ROCHELLE COMMUNITY HOSPITAL	14Z312	99914		04/17/1987	N	N	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

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

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

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

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		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: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/15/2016 1:16 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

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

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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)?	Y		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.	Y	Y	N	Y	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:	293,864	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: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/15/2016 1:16 pm

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

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	550,912	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)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141312	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/15/2016 1:16 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	09/30/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 9/15/2016 1:16 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	06/27/2016	Y	06/27/2016	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: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 9/15/2016 1:16 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141312	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/15/2016 1:16 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 9/15/2016 1:16 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	12	4,392	33,992.00	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)		12	4,392	33,992.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	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						13.00
14.00	Total (see instructions)		16	5,856	33,992.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)		16				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: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 9/15/2016 1:16 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	819	147	1,351			1.00
2.00	HMO and other (see instructions)	136	0				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	61	0	61			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)	880	147	1,412			7.00
8.00	INTENSIVE CARE UNIT	12	3	22			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)	892	150	1,434	0.00	198.51	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	198.51	27.00
28.00	Observation Bed Days		0	378			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			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: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 9/15/2016 1:16 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	280	64	505	1.00
2.00	HMO and other (see instructions)			48	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	280	64	505	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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 UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-10 | Date/Time Prepared: 9/15/2016 1:16 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.428774	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,127,883	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	10,308,694	6.00
7.00	Medicaid cost (line 1 times line 6)	4,420,100	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,292,217	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	27,816	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,292,217	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	763,827	79,352	843,179	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	327,509	34,024	361,533	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)	327,509	34,024	361,533	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,719,757	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	392,399	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,327,358	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	569,137	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	930,670	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,222,887	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		565,974	565,974	359,484	925,458	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,447,223	1,447,223	-112,897	1,334,326	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	176,776	3,250,255	3,427,031	1,188	3,428,219	4.00
5.01	00570	ADMITTING	334,008	20,743	354,751	116,411	471,162	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	435,247	416,413	851,660	0	851,660	5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL	1,132,118	2,189,547	3,321,665	-19,041	3,302,624	5.03
7.00	00700	OPERATION OF PLANT	361,549	858,159	1,219,708	0	1,219,708	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	91,269	91,269	8.00
9.00	00900	HOUSEKEEPING	278,827	118,607	397,434	-62,483	334,951	9.00
10.00	01000	DIETARY	294,270	197,091	491,361	-319,630	171,731	10.00
11.00	01100	CAFETERIA	0	0	0	319,630	319,630	11.00
13.00	01300	NURSING ADMINISTRATION	310,648	77,926	388,574	0	388,574	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	109,656	54,694	164,350	-28,786	135,564	14.00
15.00	01500	PHARMACY	163,192	1,279,179	1,442,371	0	1,442,371	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	456,333	121,886	578,219	0	578,219	16.00
17.00	01700	SOCIAL SERVICE	205,588	22,805	228,393	0	228,393	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,719,208	165,591	1,884,799	10	1,884,809	30.00
31.00	03100	INTENSIVE CARE UNIT	5,816	16,593	22,409	0	22,409	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	809,661	654,823	1,464,484	1	1,464,485	50.00
53.00	05300	ANESTHESIOLOGY	0	234,010	234,010	0	234,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	635,665	1,360,533	1,996,198	0	1,996,198	54.00
60.00	06000	LABORATORY	748,729	823,903	1,572,632	1,480	1,574,112	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	52,345	52,345	0	52,345	62.00
64.00	06400	INTRAVENOUS THERAPY	214,466	20,734	235,200	2	235,202	64.00
65.00	06500	RESPIRATORY THERAPY	43,264	993,848	1,037,112	-1,748	1,035,364	65.00
66.00	06600	PHYSICAL THERAPY	12,068	940,726	952,794	-59,377	893,417	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	59,377	59,377	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,783	10,783	0	10,783	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	331,322	331,322	0	331,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	33,882	2,628	36,510	0	36,510	90.01
91.00	09100	EMERGENCY	1,296,699	874,204	2,170,903	-1,470	2,169,433	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		179,856	179,856	-179,856	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,777,670	17,282,401	27,060,071	163,564	27,223,635	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	346,092	147,000	493,092	0	493,092	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	527,923	118,962	646,885	-163,564	483,321	194.02
194.03	07953	ASHTON CLINIC	335,129	78,252	413,381	0	413,381	194.03
194.04	07954	340B PHARMACY	0	15,650	15,650	0	15,650	194.04
200.00		TOTAL (SUM OF LINES 118-199)	10,986,814	17,642,265	28,629,079	0	28,629,079	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-97,818	827,640		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-528,762	805,564		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-17,390	3,410,829		4.00
5.01	00570	ADMITTING	0	471,162		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	851,660		5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL	-770,974	2,531,650		5.03
7.00	00700	OPERATION OF PLANT	-800	1,218,908		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,269		8.00
9.00	00900	HOUSEKEEPING	0	334,951		9.00
10.00	01000	DIETARY	0	171,731		10.00
11.00	01100	CAFETERIA	-122,887	196,743		11.00
13.00	01300	NURSING ADMINISTRATION	-2,395	386,179		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	135,564		14.00
15.00	01500	PHARMACY	0	1,442,371		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,962	570,257		16.00
17.00	01700	SOCIAL SERVICE	0	228,393		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,884,809		30.00
31.00	03100	INTENSIVE CARE UNIT	0	22,409		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-34,500	1,429,985		50.00
53.00	05300	ANESTHESIOLOGY	-233,628	382		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-18,681	1,977,517		54.00
60.00	06000	LABORATORY	0	1,574,112		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	52,345		62.00
64.00	06400	INTRAVENOUS THERAPY	0	235,202		64.00
65.00	06500	RESPIRATORY THERAPY	-114,014	921,350		65.00
66.00	06600	PHYSICAL THERAPY	-59,996	833,421		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	59,377		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,783		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	331,322		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	36,510		90.01
91.00	09100	EMERGENCY	-477,059	1,692,374		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,486,866	24,736,769		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	493,092		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	483,321		194.02
194.03	07953	ASHTON CLINIC	0	413,381		194.03
194.04	07954	340B PHARMACY	0	15,650		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-2,486,866	26,142,213		200.00

RECLASSIFICATIONS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-6 | Date/Time Prepared: 9/15/2016 1:16 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	66,755		1.00
	0		0	66,755		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	191,422	128,208		1.00
	0		191,422	128,208		
	C - RECEPTIONIST-NURSING					
1.00	ADMITTING	5.01	115,244	1,167		1.00
2.00	RESPIRATORY THERAPY	65.00	45,505	460		2.00
	0		160,749	1,627		
	D - IV PUMP					
1.00	ADULTS & PEDIATRICS	30.00	0	10		1.00
2.00	EMERGENCY	91.00	0	10		2.00
3.00	INTRAVENOUS THERAPY	64.00	0	2		3.00
4.00	OPERATING ROOM	50.00	0	1		4.00
5.00	RESPIRATORY THERAPY	65.00	0	1		5.00
	0		0	24		
	E - FITNESS CENTER					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	47,714		1.00
	0		0	47,714		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	179,832		1.00
	0		0	179,832		
	G - EKG'S					
1.00	LABORATORY	60.00	1,480	0		1.00
	0		1,480	0		
	H - FIXED EQUIPMENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	139,640		1.00
	0		0	139,640		
	I - THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	727	58,650		1.00
	0		727	58,650		
	J - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	91,269		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	91,269		
	K - DISCREET BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,188		1.00
	TOTALS		0	1,188		
500.00	Grand Total: Increases		354,378	714,907		500.00

RECLASSIFICATIONS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-6 | Date/Time Prepared: 9/15/2016 1:16 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	66,755	12		1.00
	0		0	66,755			
	B - CAFETERIA						
1.00	DIETARY	10.00	191,422	128,208	0		1.00
	0		191,422	128,208			
	C - RECEPTIONIST-NURSING						
1.00	PHYSICIANS CLINICS	194.02	160,749	1,627	0		1.00
2.00		0.00	0	0	0		2.00
	0		160,749	1,627			
	D - IV PUMP						
1.00	INTEREST EXPENSE	113.00	0	24	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
	0		0	24			
	E - FITNESS CENTER						
1.00	RESPIRATORY THERAPY	65.00	0	47,714	0		1.00
	0		0	47,714			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	179,832	11		1.00
	0		0	179,832			
	G - EKG'S						
1.00	EMERGENCY	91.00	1,480	0	0		1.00
	0		1,480	0			
	H - FIXED EQUIPMENT						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	139,640	9		1.00
	0		0	139,640			
	I - THERAPY						
1.00	PHYSICAL THERAPY	66.00	727	58,650	0		1.00
	0		727	58,650			
	J - LAUNDRY AND LINEN						
1.00	HOUSEKEEPING	9.00	0	62,483	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	28,786	0		2.00
	TOTALS		0	91,269			
	K - DISCREET BENEFITS						
1.00	PHYSICIANS CLINICS	194.02	0	1,188	0		1.00
	TOTALS		0	1,188			
500.00	Grand Total: Decreases		354,378	714,907			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 9/15/2016 1:16 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,389,097	0	0	0	0	1.00
2.00	Land Improvements	1,154,439	0	0	0	0	2.00
3.00	Buildings and Fixtures	12,179,690	279,828	0	279,828	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,668,679	148,876	0	148,876	0	5.00
6.00	Movable Equipment	8,648,323	932,092	0	932,092	853,219	6.00
7.00	HIT designated Assets	4,017,123	613,285	0	613,285	533,543	7.00
8.00	Subtotal (sum of lines 1-7)	31,057,351	1,974,081	0	1,974,081	1,386,762	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,057,351	1,974,081	0	1,974,081	1,386,762	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,389,097	0	1.00
2.00	Land Improvements	1,154,439	0	2.00
3.00	Buildings and Fixtures	12,459,518	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,817,555	0	5.00
6.00	Movable Equipment	8,727,196	0	6.00
7.00	HIT designated Assets	4,096,865	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,644,670	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,644,670	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part II Date/Time Prepared: 9/15/2016 1:16 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	550,074	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,447,223	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,997,297	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	15,900	565,974		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,447,223		2.00
3.00	Total (sum of lines 1-2)	15,900	2,013,197		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 9/15/2016 1:16 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,820,609	0	18,820,609	0.599393	40,012	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,824,061	245,215	12,578,846	0.400607	26,743	2.00
3.00	Total (sum of lines 1-2)	31,644,670	245,215	31,399,455	1.000000	66,755	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	40,012	689,714	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	26,743	778,821	0	2.00
3.00	Total (sum of lines 1-2)	0	0	66,755	1,468,535	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	82,014	40,012	0	15,900	827,640	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	26,743	0	0	805,564	2.00
3.00	Total (sum of lines 1-2)	82,014	66,755	0	15,900	1,633,204	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8 | Date/Time Prepared: 9/15/2016 1:16 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-97,818	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)	A	-800	OPERATION OF PLANT	7.00	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	-859,201			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-122,887	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,962	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	A	-527,023	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CREDENTIALING	B	-13,900	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8 | Date/Time Prepared: 9/15/2016 1:16 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01			0		0.00	0	33.01
33.02	MISC REVENUE	B	-20,274	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	FITNESS CENTER	B	-21,255	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.03
33.04	MARKETING EXPENSE	A	-185,658	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.04
33.05	LOBBYING EXPENSE	A	-12,754	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	PROPERTY TAX	A	-31,425	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.06
33.07	ASSESSMENT TAX	A	-480,827	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.07
33.08	TELEPHONE SERVICES	A	-782	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	TELEPHONE SERVICES	A	-2,807	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.09
33.10	TELEPHONE SERVICES	A	-1,739	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.10
33.11	MARKETING BENEFITS	A	-16,531	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	MISC REVENUE - DEF COMP	B	-77	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	EDUCATION MISC REVENUE	B	-2,395	NURSING ADMINISTRATION	13.00	0	33.13
33.14	MRI RENTAL INCOME	B	-18,681	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	PHYSICAL THERAPY RENTAL INCOME	B	-59,996	PHYSICAL THERAPY	66.00	0	33.15
33.16	DONATIONS	B	-2,074	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,486,866				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 9/15/2016 1:16 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	65.00	RESPIRATORY THERAPY	114,014	114,014	0	0	0	1.00
2.00	91.00	EMERGENCY	576,488	377,600	198,888	0	0	2.00
3.00	91.00	EMERGENCY	99,459	99,459	0	0	0	3.00
4.00	50.00	OPERATING ROOM	34,500	34,500	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	233,628	233,628	0	0	0	5.00
6.00	91.00	EMERGENCY	47,871	0	47,871	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	12,000	0	12,000	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			1,117,960	859,201	258,759		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	65.00	RESPIRATORY THERAPY	0	0	0	114,014		1.00
2.00	91.00	EMERGENCY	0	0	0	377,600		2.00
3.00	91.00	EMERGENCY	0	0	0	99,459		3.00
4.00	50.00	OPERATING ROOM	0	0	0	34,500		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	233,628		5.00
6.00	91.00	EMERGENCY	0	0	0	0		6.00
7.00	65.00	RESPIRATORY THERAPY	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	0	0	859,201		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/15/2016 1:16 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					366	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.63	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	522.00	9,451.45	8.17	5,046.54	0.00	9.00
10.00	AHSEA (see instructions)	90.46	78.66	38.35	16.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.33	39.33	19.18			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					47,220	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					743,451	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					313	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					790,984	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					80,745	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					871,729	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					871,729	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					14,395	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,395	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,061	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,456	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,456	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/15/2016 1:16 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	2.45	0.00	35.97	0.00	38.42	47.00
48.00	Overtime rate (see instructions)	117.99	57.53	24.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	289.08	0.00	863.28	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	6.38	0.00	93.62	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	6.38	0.00	93.62	0.00	100.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.66	38.35	16.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	502	0	1,498	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	289	0	863	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	193	0	576	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	96	0	287	0	383	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	871,729		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	16,456		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	383		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	888,568		63.00
64.00	Total cost of outside supplier services (from your records)	822,403		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	14,395		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,061		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	16,456		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,061		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	2,061		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/15/2016 1:16 pm

		Respiratory Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		366	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.63	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	13,493.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	61.76	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	30.88	30.88	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		833,359	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		833,359	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		833,359	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		833,359	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		11,302	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		11,302	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		2,061	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		13,363	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		13,363	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/15/2016 1:16 pm

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	61.76	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	833,359	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,363	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	9,979	61.00
62.00	Supplies (see instructions)	17,080	62.00
63.00	Total allowance (sum of lines 57-62)	873,781	63.00
64.00	Total cost of outside supplier services (from your records)	788,948	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	11,302	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,061	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,363	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,061	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,061	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/15/2016 1:16 pm

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		366	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.63	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	731.44	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.55	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.28	37.28	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	54,529	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	54,529	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	54,529	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	74.55	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	58,149	22.00
23.00	Total salary equivalency (see instructions)	58,149	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	13,644	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	13,644	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,061	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	15,705	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	15,705	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 9/15/2016 1:16 pm

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.55	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	58,149	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	15,705	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	73,854	63.00
64.00	Total cost of outside supplier services (from your records)	54,706	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13,644	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,061	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	15,705	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,061	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,061	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/15/2016 1:16 pm

		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	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	827,640	827,640				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	805,564		805,564			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,410,829	3,696	307	3,414,832		4.00
5.01	00570	ADMITTING	471,162	6,534	2,560	151,024	631,280	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	851,660	8,778	2,626	146,316	0	5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL	2,531,650	206,959	56,742	380,581	0	5.03
7.00	00700	OPERATION OF PLANT	1,218,908	97,261	27,219	121,541	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,269	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	334,951	6,490	0	93,732	0	9.00
10.00	01000	DIETARY	171,731	24,761	2,283	34,574	0	10.00
11.00	01100	CAFETERIA	196,743	15,752	0	64,350	0	11.00
13.00	01300	NURSING ADMINISTRATION	386,179	11,561	1,538	104,430	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	135,564	10,846	1,675	36,863	0	14.00
15.00	01500	PHARMACY	1,442,371	8,008	15,394	54,860	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	570,257	15,576	58,279	153,404	0	16.00
17.00	01700	SOCIAL SERVICE	228,393	1,683	0	69,112	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,884,809	91,255	137,466	577,945	31,227	30.00
31.00	03100	INTENSIVE CARE UNIT	22,409	18,315	3,680	1,955	739	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,429,985	82,719	281,040	272,181	61,030	50.00
53.00	05300	ANESTHESIOLOGY	382	0	13,514	0	9,202	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,977,517	55,538	125,265	213,690	163,928	54.00
60.00	06000	LABORATORY	1,574,112	22,781	19,864	252,196	103,126	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	52,345	0	840	0	1,113	62.00
64.00	06400	INTRAVENOUS THERAPY	235,202	11,759	3,848	72,096	6,692	64.00
65.00	06500	RESPIRATORY THERAPY	921,350	18,678	2,930	29,841	16,330	65.00
66.00	06600	PHYSICAL THERAPY	833,421	23,408	3,803	3,812	37,957	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,377	1,496	244	244	2,433	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,783	0	0	0	5,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	331,322	0	0	0	12,461	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	114,934	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	36,510	2,893	0	11,390	217	90.01
91.00	09100	EMERGENCY	1,692,374	52,535	26,692	418,198	64,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,736,769	799,282	787,809	3,264,335	631,280	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,093	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	493,092	0	1,304	67,429	0	194.00
194.01	07951	FOUNDATION	0	264	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	483,321	23,001	16,393	49,105	0	194.02
194.03	07953	ASHTON CLINIC	413,381	0	58	33,963	0	194.03
194.04	07954	340B PHARMACY	15,650	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	26,142,213	827,640	805,564	3,414,832	631,280	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.02	5A.02	5.03	7.00	8.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,009,380					5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL	0	3,175,932	3,175,932			5.03
7.00	00700	OPERATION OF PLANT	0	1,464,929	202,581	1,667,510		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,269	12,621	0	103,890	8.00
9.00	00900	HOUSEKEEPING	0	435,173	60,179	21,455	0	9.00
10.00	01000	DIETARY	0	233,349	32,269	81,855	0	10.00
11.00	01100	CAFETERIA	0	276,845	38,284	52,073	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	503,708	69,656	38,219	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	184,948	25,576	35,855	0	14.00
15.00	01500	PHARMACY	0	1,520,633	210,284	26,473	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	797,516	110,286	51,491	0	16.00
17.00	01700	SOCIAL SERVICE	0	299,188	41,374	5,564	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,428	2,772,130	383,350	301,675	26,208	30.00
31.00	03100	INTENSIVE CARE UNIT	1,170	48,268	6,675	60,546	408	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	96,603	2,223,558	307,489	273,458	21,040	50.00
53.00	05300	ANESTHESIOLOGY	14,565	37,663	5,208	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	259,454	2,795,392	386,560	183,602	24,146	54.00
60.00	06000	LABORATORY	163,235	2,135,314	295,286	75,310	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,762	56,060	7,752	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	10,593	340,190	47,044	38,873	0	64.00
65.00	06500	RESPIRATORY THERAPY	29,186	1,018,315	140,820	61,746	0	65.00
66.00	06600	PHYSICAL THERAPY	60,081	962,482	133,099	77,383	9,320	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,851	67,645	9,354	4,946	598	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,475	24,612	3,404	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,723	363,506	50,268	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181,926	296,860	41,052	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	343	51,353	7,101	9,564	0	90.01
91.00	09100	EMERGENCY	108,985	2,363,321	326,817	173,675	22,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,009,380	24,540,159	2,954,389	1,573,763	103,890	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,093	704	16,837	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	561,825	77,693	0	0	194.00
194.01	07951	FOUNDATION	0	264	37	873	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	571,820	79,075	76,037	0	194.02
194.03	07953	ASHTON CLINIC	0	447,402	61,870	0	0	194.03
194.04	07954	340B PHARMACY	0	15,650	2,164	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,009,380	26,142,213	3,175,932	1,667,510	103,890	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	516,807					9.00
10.00	01000	DIETARY	25,700	373,173				10.00
11.00	01100	CAFETERIA	16,349	0	383,551			11.00
13.00	01300	NURSING ADMINISTRATION	11,999	0	13,116	636,698		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,257	0	8,722	0	266,358	14.00
15.00	01500	PHARMACY	8,312	0	6,761	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,167	0	32,588	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,747	0	8,079	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,716	277,295	104,526	290,237	0	30.00
31.00	03100	INTENSIVE CARE UNIT	19,009	5,298	304	948	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	85,857	23,752	38,571	105,015	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,645	87	36,881	0	0	54.00
60.00	06000	LABORATORY	23,645	0	52,296	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	12,205	41,686	9,533	26,551	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,386	0	2,603	7,206	0	65.00
66.00	06600	PHYSICAL THERAPY	24,296	0	169	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,553	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	266,358	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	3,003	0	1,623	1,241	0	90.01
91.00	09100	EMERGENCY	54,528	25,055	67,779	181,829	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	487,374	373,173	383,551	613,027	266,358	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,286	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	274	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	23,873	0	0	23,671	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	516,807	373,173	383,551	636,698	266,358	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	1,772,463					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,008,048				16.00
17.00	01700	SOCIAL SERVICE	0	0	355,952			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	202,963	350,248	4,803,348	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,704	147,160	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	59,695	0	3,138,435	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	42,871	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,348	0	3,572,661	0	54.00
60.00	06000	LABORATORY	0	153,217	0	2,735,068	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	63,812	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	97,900	0	613,982	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,975	0	1,255,051	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,592	0	1,221,341	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	929	0	85,025	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	294,374	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	413,774	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,772,463	0	0	2,110,375	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	73,885	0	90.01
91.00	09100	EMERGENCY	0	385,429	0	3,600,603	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,772,463	1,008,048	355,952	24,171,765	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	27,920	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	639,518	0	194.00
194.01	07951	FOUNDATION	0	0	0	1,448	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	774,476	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	509,272	0	194.03
194.04	07954	340B PHARMACY	0	0	0	17,814	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,772,463	1,008,048	355,952	26,142,213	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	Total		
			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
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,803,348		30.00
31.00	03100	INTENSIVE CARE UNIT	147,160		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,138,435		50.00
53.00	05300	ANESTHESIOLOGY	42,871		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,572,661		54.00
60.00	06000	LABORATORY	2,735,068		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,812		62.00
64.00	06400	INTRAVENOUS THERAPY	613,982		64.00
65.00	06500	RESPIRATORY THERAPY	1,255,051		65.00
66.00	06600	PHYSICAL THERAPY	1,221,341		66.00
67.00	06700	OCCUPATIONAL THERAPY	85,025		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	294,374		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	413,774		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,110,375		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	CLINIC	73,885		90.01
91.00	09100	EMERGENCY	3,600,603		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,171,765		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,920		190.00
194.00	07950	OCCUPATIONAL HEALTH	639,518		194.00
194.01	07951	FOUNDATION	1,448		194.01
194.02	07952	PHYSICIANS CLINICS	774,476		194.02
194.03	07953	ASHTON CLINIC	509,272		194.03
194.04	07954	340B PHARMACY	17,814		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	26,142,213		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,696	307	4,003	4,003	4.00
5.01	00570	ADMITTING	0	6,534	2,560	9,094	177	5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	8,778	2,626	11,404	171	5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL	0	206,959	56,742	263,701	446	5.03
7.00	00700	OPERATION OF PLANT	0	97,261	27,219	124,480	142	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,490	0	6,490	110	9.00
10.00	01000	DIETARY	0	24,761	2,283	27,044	41	10.00
11.00	01100	CAFETERIA	0	15,752	0	15,752	75	11.00
13.00	01300	NURSING ADMINISTRATION	0	11,561	1,538	13,099	122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,846	1,675	12,521	43	14.00
15.00	01500	PHARMACY	0	8,008	15,394	23,402	64	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,576	58,279	73,855	180	16.00
17.00	01700	SOCIAL SERVICE	0	1,683	0	1,683	81	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10	91,255	137,466	228,731	681	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,315	3,680	21,995	2	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1	82,719	281,040	363,760	319	50.00
53.00	05300	ANESTHESIOLOGY	0	0	13,514	13,514	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,538	125,265	180,803	250	54.00
60.00	06000	LABORATORY	0	22,781	19,864	42,645	296	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	840	840	0	62.00
64.00	06400	INTRAVENOUS THERAPY	2	11,759	3,848	15,609	84	64.00
65.00	06500	RESPIRATORY THERAPY	1	18,678	2,930	21,609	35	65.00
66.00	06600	PHYSICAL THERAPY	0	23,408	3,803	27,211	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,496	244	1,740	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	2,893	0	2,893	13	90.01
91.00	09100	EMERGENCY	10	52,535	26,692	79,237	490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24	799,282	787,809	1,587,115	3,826	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,093	0	5,093	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	1,304	1,304	79	194.00
194.01	07951	FOUNDATION	0	264	0	264	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	23,001	16,393	39,394	58	194.02
194.03	07953	ASHTON CLINIC	0	0	58	58	40	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24	827,640	805,564	1,633,228	4,003	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	7.00	8.00	
		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
5.01	00570	ADMITTING	9,271					5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	11,575				5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	264,147			5.03
7.00	00700	OPERATION OF PLANT	0	0	16,850	141,472		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,050	0	1,050	8.00
9.00	00900	HOUSEKEEPING	0	0	5,005	1,820	0	9.00
10.00	01000	DIETARY	0	0	2,684	6,945	0	10.00
11.00	01100	CAFETERIA	0	0	3,184	4,418	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	5,794	3,242	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,127	3,042	0	14.00
15.00	01500	PHARMACY	0	0	17,490	2,246	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	9,173	4,369	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	3,441	472	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	457	566	31,885	25,594	265	30.00
31.00	03100	INTENSIVE CARE UNIT	11	13	555	5,137	4	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	894	1,106	25,575	23,200	213	50.00
53.00	05300	ANESTHESIOLOGY	135	167	433	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,428	2,988	32,143	15,577	244	54.00
60.00	06000	LABORATORY	1,510	1,869	24,560	6,389	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	16	20	645	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	98	121	3,913	3,298	0	64.00
65.00	06500	RESPIRATORY THERAPY	239	334	11,713	5,239	0	65.00
66.00	06600	PHYSICAL THERAPY	556	688	11,070	6,565	94	66.00
67.00	06700	OCCUPATIONAL THERAPY	36	44	778	420	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	78	97	283	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	182	226	4,181	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,683	2,084	3,414	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	3	4	591	811	0	90.01
91.00	09100	EMERGENCY	945	1,248	27,183	14,735	224	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,271	11,575	245,720	133,519	1,050	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	59	1,428	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	6,462	0	0	194.00
194.01	07951	FOUNDATION	0	0	3	74	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	6,577	6,451	0	194.02
194.03	07953	ASHTON CLINIC	0	0	5,146	0	0	194.03
194.04	07954	340B PHARMACY	0	0	180	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,271	11,575	264,147	141,472	1,050	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	13,425					9.00
10.00	01000	DIETARY	668	37,382				10.00
11.00	01100	CAFETERIA	425	0	23,854			11.00
13.00	01300	NURSING ADMINISTRATION	312	0	816	23,385		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	292	0	542	0	18,567	14.00
15.00	01500	PHARMACY	216	0	420	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	420	0	2,027	0	0	16.00
17.00	01700	SOCIAL SERVICE	45	0	502	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,462	27,777	6,501	10,660	0	30.00
31.00	03100	INTENSIVE CARE UNIT	494	531	19	35	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,230	2,379	2,399	3,857	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,497	9	2,294	0	0	54.00
60.00	06000	LABORATORY	614	0	3,252	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	317	4,176	593	975	0	64.00
65.00	06500	RESPIRATORY THERAPY	504	0	162	265	0	65.00
66.00	06600	PHYSICAL THERAPY	631	0	11	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	40	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	78	0	101	46	0	90.01
91.00	09100	EMERGENCY	1,416	2,510	4,215	6,678	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,661	37,382	23,854	22,516	18,567	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	137	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	7	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	620	0	0	869	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,425	37,382	23,854	23,385	18,567	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	43,838					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	90,024				16.00
17.00	01700	SOCIAL SERVICE	0	0	6,224			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	18,126	6,124	359,829	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	100	28,896	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,331	0	431,263	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	14,249	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,890	0	246,123	0	54.00
60.00	06000	LABORATORY	0	13,683	0	94,818	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,521	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	8,743	0	37,927	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	444	0	40,544	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,303	0	48,133	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	83	0	3,147	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	19,025	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,589	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,838	0	0	51,019	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	4,540	0	90.01
91.00	09100	EMERGENCY	0	34,421	0	173,302	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,838	90,024	6,224	1,558,925	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	6,717	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	7,845	0	194.00
194.01	07951	FOUNDATION	0	0	0	348	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	0	53,969	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	5,244	0	194.03
194.04	07954	340B PHARMACY	0	0	0	180	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	43,838	90,024	6,224	1,633,228	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	Total		
			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
5.01	00570	ADMITTING			5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL			5.03
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	359,829		30.00
31.00	03100	INTENSIVE CARE UNIT	28,896		31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	431,263		50.00
53.00	05300	ANESTHESIOLOGY	14,249		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,123		54.00
60.00	06000	LABORATORY	94,818		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,521		62.00
64.00	06400	INTRAVENOUS THERAPY	37,927		64.00
65.00	06500	RESPIRATORY THERAPY	40,544		65.00
66.00	06600	PHYSICAL THERAPY	48,133		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,147		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,025		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,589		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,019		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
90.01	09001	CLINIC	4,540		90.01
91.00	09100	EMERGENCY	173,302		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,558,925		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,717		190.00
194.00	07950	OCCUPATIONAL HEALTH	7,845		194.00
194.01	07951	FOUNDATION	348		194.01
194.02	07952	PHYSICIANS CLINICS	53,969		194.02
194.03	07953	ASHTON CLINIC	5,244		194.03
194.04	07954	340B PHARMACY	180		194.04
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,633,228		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	75,241					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		778,821				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	336	297	10,158,129			4.00
5.01	00570	ADMITTING	594	2,475	449,252	56,374,171		5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE	798	2,539	435,247	0	56,947,916	5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL	18,815	54,858	1,132,120	0	0	5.03
7.00	00700	OPERATION OF PLANT	8,842	26,315	361,549	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	590	0	278,827	0	0	9.00
10.00	01000	DIETARY	2,251	2,207	102,848	0	0	10.00
11.00	01100	CAFETERIA	1,432	0	191,422	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,051	1,487	310,648	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	986	1,619	109,656	0	0	14.00
15.00	01500	PHARMACY	728	14,883	163,192	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,416	56,344	456,333	0	0	16.00
17.00	01700	SOCIAL SERVICE	153	0	205,588	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,296	132,902	1,719,208	2,788,589	2,788,589	30.00
31.00	03100	INTENSIVE CARE UNIT	1,665	3,558	5,816	66,000	66,000	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,520	271,711	809,661	5,450,113	5,450,113	50.00
53.00	05300	ANESTHESIOLOGY	0	13,065	0	821,712	821,712	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,049	121,106	635,665	14,638,979	14,638,979	54.00
60.00	06000	LABORATORY	2,071	19,205	750,209	9,209,296	9,209,296	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	812	0	99,415	99,415	62.00
64.00	06400	INTRAVENOUS THERAPY	1,069	3,720	214,466	597,648	597,648	64.00
65.00	06500	RESPIRATORY THERAPY	1,698	2,833	88,769	1,458,254	1,646,613	65.00
66.00	06600	PHYSICAL THERAPY	2,128	3,677	11,341	3,389,616	3,389,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	136	236	727	217,260	217,260	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	478,142	478,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,112,746	1,112,746	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,263,790	10,263,790	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	263	0	33,882	19,355	19,355	90.01
91.00	09100	EMERGENCY	4,776	25,806	1,244,018	5,763,256	6,148,642	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,663	761,655	9,710,444	56,374,171	56,947,916	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	463	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	1,261	200,581	0	0	194.00
194.01	07951	FOUNDATION	24	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	2,091	15,849	146,073	0	0	194.02
194.03	07953	ASHTON CLINIC	0	56	101,031	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	827,640	805,564	3,414,832	631,280	1,009,380	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.999854	1.034338	0.336167	0.011198	0.017725	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,003	9,271	11,575	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000394	0.000164	0.000203	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.03	5.03	7.00	8.00	9.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL	-3,175,932	22,966,281				5.03
7.00	00700	OPERATION OF PLANT	0	1,464,929	45,856			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	91,269	0	132,801		8.00
9.00	00900	HOUSEKEEPING	0	435,173	590	0	45,266	9.00
10.00	01000	DIETARY	0	233,349	2,251	0	2,251	10.00
11.00	01100	CAFETERIA	0	276,845	1,432	0	1,432	11.00
13.00	01300	NURSING ADMINISTRATION	0	503,708	1,051	0	1,051	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	184,948	986	0	986	14.00
15.00	01500	PHARMACY	0	1,520,633	728	0	728	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	797,516	1,416	0	1,416	16.00
17.00	01700	SOCIAL SERVICE	0	299,188	153	0	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,772,130	8,296	33,500	8,296	30.00
31.00	03100	INTENSIVE CARE UNIT	0	48,268	1,665	522	1,665	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,223,558	7,520	26,895	7,520	50.00
53.00	05300	ANESTHESIOLOGY	0	37,663	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,795,392	5,049	30,866	5,049	54.00
60.00	06000	LABORATORY	0	2,135,314	2,071	0	2,071	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	56,060	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	340,190	1,069	0	1,069	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,018,315	1,698	0	1,698	65.00
66.00	06600	PHYSICAL THERAPY	0	962,482	2,128	11,914	2,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67,645	136	764	136	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,612	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	363,506	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	296,860	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	51,353	263	0	263	90.01
91.00	09100	EMERGENCY	0	2,363,321	4,776	28,340	4,776	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,175,932	21,364,227	43,278	132,801	42,688	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,093	463	0	463	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	561,825	0	0	0	194.00
194.01	07951	FOUNDATION	0	264	24	0	24	194.01
194.02	07952	PHYSICIANS CLINICS	0	571,820	2,091	0	2,091	194.02
194.03	07953	ASHTON CLINIC	0	447,402	0	0	0	194.03
194.04	07954	340B PHARMACY	0	15,650	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,175,932	1,667,510	103,890	516,807	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.138287	36.364053	0.782298	11.417112	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		264,147	141,472	1,050	13,425	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.011502	3.085136	0.007907	0.296580	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		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
5.01	00570	ADMITTING						5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	8,594					10.00
11.00	01100	CAFETERIA	0	11,346				11.00
13.00	01300	NURSING ADMINISTRATION	0	388	121,580			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	258	0	100		14.00
15.00	01500	PHARMACY	0	200	0	0	1,159,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	964	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	239	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,386	3,092	55,422	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	122	9	181	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	547	1,141	20,053	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2	1,091	0	0	0	54.00
60.00	06000	LABORATORY	0	1,547	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	960	282	5,070	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	77	1,376	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	100	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	1,159,919	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	48	237	0	0	90.01
91.00	09100	EMERGENCY	577	2,005	34,721	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,594	11,346	117,060	100	1,159,919	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	0	0	0	0	0	194.01
194.02	07952	PHYSICIANS CLINICS	0	0	4,520	0	0	194.02
194.03	07953	ASHTON CLINIC	0	0	0	0	0	194.03
194.04	07954	340B PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	373,173	383,551	636,698	266,358	1,772,463	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.422504	33.804953	5.236865	2,663.580000	1.528092	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,382	23,854	23,385	18,567	43,838	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.349779	2.102415	0.192342	185.670000	0.037794	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/15/2016 1:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)		
			16.00	17.00		
		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
5.01	00570	ADMITTING				5.01
5.02	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.02
5.03	00590	OTHER ADMINISTRATIVE AND GENERAL				5.03
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	75,990			16.00
17.00	01700	SOCIAL SERVICE	0	1,373		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	15,300	1,351		30.00
31.00	03100	INTENSIVE CARE UNIT	0	22		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,500	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,660	0		54.00
60.00	06000	LABORATORY	11,550	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	7,380	0		64.00
65.00	06500	RESPIRATORY THERAPY	375	0		65.00
66.00	06600	PHYSICAL THERAPY	1,100	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	70	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
91.00	09100	EMERGENCY	29,055	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,990	1,373		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OCCUPATIONAL HEALTH	0	0		194.00
194.01	07951	FOUNDATION	0	0		194.01
194.02	07952	PHYSICIANS CLINICS	0	0		194.02
194.03	07953	ASHTON CLINIC	0	0		194.03
194.04	07954	340B PHARMACY	0	0		194.04
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,008,048	355,952		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.265535	259.251275		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	90,024	6,224		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.184682	4.533139		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,803,348		4,803,348	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	147,160		147,160	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,138,435		3,138,435	0	0	50.00
53.00	05300	ANESTHESIOLOGY	42,871		42,871	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,572,661		3,572,661	0	0	54.00
60.00	06000	LABORATORY	2,735,068		2,735,068	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,812		63,812	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	613,982		613,982	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,255,051	0	1,255,051	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,221,341	0	1,221,341	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,025	0	85,025	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	294,374		294,374	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	413,774		413,774	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,110,375		2,110,375	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	73,885		73,885	0	0	90.01
91.00	09100	EMERGENCY	3,600,603		3,600,603	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,014,337		1,014,337		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,186,102	0	25,186,102	0	0	200.00
201.00		Less Observation Beds	1,014,337		1,014,337		0	201.00
202.00		Total (see instructions)	24,171,765	0	24,171,765	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,837,260		1,837,260			30.00
31.00	03100	INTENSIVE CARE UNIT	66,000		66,000			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,085,274	4,364,839	5,450,113	0.575848	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	118,366	703,346	821,712	0.052173	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,659	14,080,320	14,638,979	0.244051	0.000000	54.00
60.00	06000	LABORATORY	617,847	8,591,449	9,209,296	0.296990	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	42,981	56,434	99,415	0.641875	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	597,648	597,648	1.027330	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	422,177	1,036,077	1,458,254	0.860653	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	116,121	3,273,495	3,389,616	0.360318	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	217,260	217,260	0.391351	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	320,595	157,547	478,142	0.615662	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	752,560	360,186	1,112,746	0.371849	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,711,694	8,552,096	10,263,790	0.205614	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	19,355	19,355	3.817360	0.000000	90.01
91.00	09100	EMERGENCY	1,626	5,761,630	5,763,256	0.624752	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	951,329	951,329	1.066232	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,651,160	48,723,011	56,374,171			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,651,160	48,723,011	56,374,171			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/15/2016 1:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,803,348		4,803,348	0	4,803,348	30.00
31.00	03100	INTENSIVE CARE UNIT	147,160		147,160	0	147,160	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,138,435		3,138,435	0	3,138,435	50.00
53.00	05300	ANESTHESIOLOGY	42,871		42,871	0	42,871	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,572,661		3,572,661	0	3,572,661	54.00
60.00	06000	LABORATORY	2,735,068		2,735,068	0	2,735,068	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	63,812		63,812	0	63,812	62.00
64.00	06400	INTRAVENOUS THERAPY	613,982		613,982	0	613,982	64.00
65.00	06500	RESPIRATORY THERAPY	1,255,051	0	1,255,051	0	1,255,051	65.00
66.00	06600	PHYSICAL THERAPY	1,221,341	0	1,221,341	0	1,221,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,025	0	85,025	0	85,025	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	294,374		294,374	0	294,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	413,774		413,774	0	413,774	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,110,375		2,110,375	0	2,110,375	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	CLINIC	73,885		73,885	0	73,885	90.01
91.00	09100	EMERGENCY	3,600,603		3,600,603	0	3,600,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,014,337		1,014,337		1,014,337	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,186,102	0	25,186,102	0	25,186,102	200.00
201.00		Less Observation Beds	1,014,337		1,014,337		1,014,337	201.00
202.00		Total (see instructions)	24,171,765	0	24,171,765	0	24,171,765	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/15/2016 1:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,837,260		1,837,260			30.00
31.00	03100	INTENSIVE CARE UNIT	66,000		66,000			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,085,274	4,364,839	5,450,113	0.575848	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	118,366	703,346	821,712	0.052173	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,659	14,080,320	14,638,979	0.244051	0.000000	54.00
60.00	06000	LABORATORY	617,847	8,591,449	9,209,296	0.296990	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	42,981	56,434	99,415	0.641875	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	597,648	597,648	1.027330	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	422,177	1,036,077	1,458,254	0.860653	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	116,121	3,273,495	3,389,616	0.360318	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	217,260	217,260	0.391351	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	320,595	157,547	478,142	0.615662	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	752,560	360,186	1,112,746	0.371849	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,711,694	8,552,096	10,263,790	0.205614	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	CLINIC	0	19,355	19,355	3.817360	0.000000	90.01
91.00	09100	EMERGENCY	1,626	5,761,630	5,763,256	0.624752	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	951,329	951,329	1.066232	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,651,160	48,723,011	56,374,171			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,651,160	48,723,011	56,374,171			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/15/2016 1:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	CLINIC	0.000000	90.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		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 ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part II Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		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	431,263	5,450,113	0.079129	460,578	36,445	50.00
53.00	05300	ANESTHESIOLOGY	14,249	821,712	0.017341	49,312	855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,123	14,638,979	0.016813	326,371	5,487	54.00
60.00	06000	LABORATORY	94,818	9,209,296	0.010296	408,482	4,206	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,521	99,415	0.015300	26,772	410	62.00
64.00	06400	INTRAVENOUS THERAPY	37,927	597,648	0.063460	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	40,544	1,458,254	0.027803	281,330	7,822	65.00
66.00	06600	PHYSICAL THERAPY	48,133	3,389,616	0.014200	73,093	1,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,147	217,260	0.014485	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,025	478,142	0.039789	229,127	9,117	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,589	1,112,746	0.004124	437,770	1,805	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	51,019	10,263,790	0.004971	961,269	4,778	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	CLINIC	4,540	19,355	0.234565	0	0	90.01
91.00	09100	EMERGENCY	173,302	5,763,256	0.030070	1,626	49	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	75,986	951,329	0.079874	0	0	92.00
200.00		Total (lines 50-199)	1,246,186	54,470,911		3,255,730	72,012	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
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: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		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	5,450,113	0.000000	0.000000	460,578	50.00
53.00	05300	ANESTHESIOLOGY	0	821,712	0.000000	0.000000	49,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,638,979	0.000000	0.000000	326,371	54.00
60.00	06000	LABORATORY	0	9,209,296	0.000000	0.000000	408,482	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	99,415	0.000000	0.000000	26,772	62.00
64.00	06400	INTRAVENOUS THERAPY	0	597,648	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,458,254	0.000000	0.000000	281,330	65.00
66.00	06600	PHYSICAL THERAPY	0	3,389,616	0.000000	0.000000	73,093	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	217,260	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	478,142	0.000000	0.000000	229,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,112,746	0.000000	0.000000	437,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,263,790	0.000000	0.000000	961,269	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	19,355	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	5,763,256	0.000000	0.000000	1,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	951,329	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	54,470,911			3,255,730	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	CLINIC	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.575848	0	1,569,475	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.052173	0	260,036	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244051	0	4,107,009	0	0	54.00
60.00	06000	LABORATORY	0.296990	0	3,199,469	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.641875	0	23,937	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.027330	0	258,896	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.860653	0	413,353	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.360318	0	891,219	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.391351	0	40,889	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615662	0	68,384	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371849	0	68,218	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205614	0	3,849,377	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	3.817360	0	7,546	0	0	90.01
91.00	09100	EMERGENCY	0.624752	0	1,492,473	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.066232	0	398,746	0	0	92.00
200.00		Subtotal (see instructions)		0	16,649,027	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	16,649,027	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	903,779	0	50.00
53.00	05300	ANESTHESIOLOGY	13,567	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,002,320	0	54.00
60.00	06000	LABORATORY	950,210	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	15,365	0	62.00
64.00	06400	INTRAVENOUS THERAPY	265,972	0	64.00
65.00	06500	RESPIRATORY THERAPY	355,753	0	65.00
66.00	06600	PHYSICAL THERAPY	321,122	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,002	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,101	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,367	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791,486	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	28,806	0	90.01
91.00	09100	EMERGENCY	932,425	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	425,156	0	92.00
200.00		Subtotal (see instructions)	6,089,431	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	6,089,431	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141312 | Component CCN: 14Z312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Swing Beds - SNF

		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	0.575848	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.052173	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244051	0	0	0	0	54.00
60.00	06000	LABORATORY	0.296990	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.641875	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.027330	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.860653	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.360318	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.391351	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615662	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371849	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205614	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	CLINIC	3.817360	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.624752	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.066232	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141312 | Component CCN: 14Z312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Swing Beds - SNF

		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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
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)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,790	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,729	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)	1,351	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	61	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)	819	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)	61	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	169.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	169.32	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,803,348	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)	163,689	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,639,659	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,639,659	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)	2,683.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,197,729	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,197,729	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	147,160	22	6,689.09	12	80,269	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,256,926	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,534,924	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	163,689	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)	163,689	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)	378	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,683.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,014,337	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	359,829	4,803,348	0.074912	1,014,337	75,986	90.00
91.00	Nursing School cost	0	4,803,348	0.000000	1,014,337	0	91.00
92.00	Allied health cost	0	4,803,348	0.000000	1,014,337	0	92.00
93.00	All other Medical Education	0	4,803,348	0.000000	1,014,337	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-3 | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,064,660		30.00
31.00	03100	INTENSIVE CARE UNIT		36,000		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.575848	460,578	265,223	50.00
53.00	05300	ANESTHESIOLOGY	0.052173	49,312	2,573	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244051	326,371	79,651	54.00
60.00	06000	LABORATORY	0.296990	408,482	121,315	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.641875	26,772	17,184	62.00
64.00	06400	INTRAVENOUS THERAPY	1.027330	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.860653	281,330	242,128	65.00
66.00	06600	PHYSICAL THERAPY	0.360318	73,093	26,337	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.391351	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615662	229,127	141,065	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371849	437,770	162,784	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205614	961,269	197,650	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	3.817360	0	0	90.01
91.00	09100	EMERGENCY	0.624752	1,626	1,016	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.066232	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,255,730	1,256,926	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,255,730		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-3

Component CCN: 14Z312 | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Swing Beds - SNF

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.575848	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.052173	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.244051	1,737	424	54.00
60.00	06000	LABORATORY	0.296990	4,709	1,399	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.641875	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.027330	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.860653	3,722	3,203	65.00
66.00	06600	PHYSICAL THERAPY	0.360318	20,236	7,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.391351	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.615662	1,360	837	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371849	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205614	38,182	7,851	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	CLINIC	3.817360	0	0	90.01
91.00	09100	EMERGENCY	0.624752	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.066232	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		69,946	21,005	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)		69,946		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141312	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prepared: 9/15/2016 1:16 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,089,431	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,089,431	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	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)	6,150,325	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)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	34,231	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,731,800	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,384,294	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,384,294	30.00
31.00	Primary payer payments	2,506	31.00
32.00	Subtotal (line 30 minus line 31)	3,381,788	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)	534,846	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	347,650	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	429,732	36.00
37.00	Subtotal (see instructions)	3,729,438	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,729,438	40.00
40.01	Sequestration adjustment (see instructions)	74,589	40.01
41.00	Interim payments	3,819,957	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-165,108	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: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,471,566		3,819,957	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	12/15/2015	85,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		85,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,557,166		3,819,957	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		718,440		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		165,108	6.02
7.00	Total Medicare program liability (see instructions)		3,275,606		3,654,849	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 9/15/2016 1:16 pm

Component CCN: 14Z312 | Title XVIII | Swing Beds - SNF

		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		145,898		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		145,898		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		36,912		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		182,810		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141312	Period: From 05/01/2015 To 04/30/2016	Worksheet E-1 Part II Date/Time Prepared: 9/15/2016 1:16 pm
	Title XVIII	Hospital	Cost

		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	505	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	831	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	136	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,373	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	56,374,171	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	843,179	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	550,912	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	504,084	8.00
9.00	Sequestration adjustment amount (see instructions)	10,082	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	494,002	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	494,002	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141312 | Component CCN: 14Z312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-2 | Date/Time Prepared: 9/15/2016 1:16 pm

Title XVIII | Swing Beds - SNF

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	165,326	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	21,215	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	61	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	186,541	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	186,541	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	186,541	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	186,541	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	186,541	0	19.00
19.01	Sequestration adjustment (see instructions)	3,731	0	19.01
20.00	Interim payments	145,898	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	36,912	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141312	Period: From 05/01/2015 To 04/30/2016	Worksheet E-3 Part V Date/Time Prepared: 9/15/2016 1:16 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,534,924	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,534,924	4.00
5.00	Primary payer payments	659	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,569,614	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,569,614	19.00
20.00	Deductibles (exclude professional component)	271,908	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,297,706	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,297,706	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	68,844	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	44,749	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,559	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,342,455	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,342,455	30.00
30.01	Sequestration adjustment (see instructions)	66,849	30.01
31.00	Interim payments	2,557,166	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	718,440	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G | Date/Time Prepared: 9/15/2016 1:16 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	7,147,925	0	0	0	1.00
2.00	Temporary investments	7,379,044	0	0	0	2.00
3.00	Notes receivable	600,303	0	0	0	3.00
4.00	Accounts receivable	5,452,943	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	216,095	0	0	0	7.00
8.00	Prepaid expenses	1,169,235	0	0	0	8.00
9.00	Other current assets	48,135	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)	22,013,680	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,389,097	0	0	0	12.00
13.00	Land improvements	1,154,439	0	0	0	13.00
14.00	Accumulated depreciation	-1,055,925	0	0	0	14.00
15.00	Buildings	12,459,518	0	0	0	15.00
16.00	Accumulated depreciation	-7,696,879	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	1,817,555	0	0	0	19.00
20.00	Accumulated depreciation	-798,083	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	8,727,196	0	0	0	23.00
24.00	Accumulated depreciation	-5,895,501	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	4,096,866	0	0	0	27.00
28.00	Accumulated depreciation	-3,303,745	0	0	0	28.00
29.00	Minor equipment-nondepreciable	8,219,540	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	21,114,078	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	266,830	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	266,830	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,394,588	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,356,019	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,544,788	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	524,036	0	0	0	40.00
41.00	Deferred income	39,996	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,376,167	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,841,006	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	7,482,923	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,482,923	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,323,929	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,070,659				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)	30,070,659	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,394,588	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-1 | Date/Time Prepared: 9/15/2016 1:16 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,191,287		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,879,372				2.00
3.00	Total (sum of line 1 and line 2)		30,070,659		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,070,659		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,070,659		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141312 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/15/2016 1:16 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,764,060		1,764,060	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	73,200		73,200	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,837,260		1,837,260	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	66,000		66,000	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)	66,000		66,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,903,260		1,903,260	17.00
18.00	Ancillary services	5,746,274	41,990,697	47,736,971	18.00
19.00	Outpatient services	1,626	6,732,314	6,733,940	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				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 CHARGES	0	1,696,053	1,696,053	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,651,160	50,419,064	58,070,224	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,629,079		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)		28,629,079		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141312	Period: From 05/01/2015 To 04/30/2016	Worksheet G-3 Date/Time Prepared: 9/15/2016 1:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	58,070,224	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,880,529	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,189,695	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,629,079	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,560,616	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	58,704	6.00
7.00	Income from investments	97,895	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	122,887	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	7,962	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	144,788	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	28,437	24.00
24.01	340B INCOME	33,667	24.01
24.02	FITNESS CENTER	21,255	24.02
24.03	MISCELLANEOUS INCOME	45,385	24.03
25.00	Total other income (sum of lines 6-24)	560,980	25.00
26.00	Total (line 5 plus line 25)	3,121,596	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	133,924	27.00
27.01	LOSS ON INVESTMENT IN ROCHELLE MG	742,603	27.01
27.02	UNREALIZED LOSS ON INVESTMENTS	365,697	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	1,242,224	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,879,372	29.00