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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet S Parts I-III Date/Time Prepared: 9/27/2017 1:07 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/27/2017 Time: 1:07 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PEKIN MEMORIAL HOSPITAL (14-0120) for the cost reporting period beginning 05/01/2016 and ending 04/30/2017 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	100,434	-64,223	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	100,434	-64,223	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 1:07 pm

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

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

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2016	04/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	685	696	0	0	862	67	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 1:07 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 1:07 pm

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

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 1:07 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)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	262,816	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: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 1:07 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H076	140.00

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/27/2017 1:07 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)	05/01/2016	04/30/2017	170.00
		1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 9/27/2017 1:07 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.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	06/22/2017	Y	06/22/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 9/27/2017 1:07 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY		RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544		PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part II Date/Time Prepared: 9/27/2017 1:07 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: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 9/27/2017 1:07 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	99	36,135	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		99	36,135	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		107	39,055	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		107				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 9/27/2017 1:07 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)	5,383	397	10,080			1.00
2.00	HMO and other (see instructions)	1,790	1,310				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,383	397	10,080			7.00
8.00	INTENSIVE CARE UNIT	503	72	1,136			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		464	741			13.00
14.00	Total (see instructions)	5,886	933	11,957	0.00	478.04	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	4,816	0	8,150	0.00	8.94	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	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	486.98	27.00
28.00	Observation Bed Days		504	1,957			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			92			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	67	100			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: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 9/27/2017 1:07 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,315	382	2,971	1.00
2.00	HMO and other (see instructions)			404	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,315	382	2,971	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 9/27/2017 1:07 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	24,437,458	0	24,437,458	1,012,927.05	24.13	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		2,089,286	0	2,089,286	48,192.00	43.35	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		616,076	0	616,076	20,363.37	30.25	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,975,395	0	1,975,395	42,470.59	46.51	11.00
12.00	Contract labor: Top level management and other management and administrative services		12,000	0	12,000	120.00	100.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		1,884,736	0	1,884,736	45,296.52	41.61	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,686,412	0	5,686,412			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		130,845	0	130,845			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	224,743	224,743	8,368.25	26.86	26.00
27.00	Administrative & General	5.00	5,505,057	-218,543	5,286,514	227,047.45	23.28	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 9/27/2017 1:07 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		611,550	0	611,550	2,726.09	224.33	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	586,509	0	586,509	23,689.50	24.76	30.00
31.00	Laundry & Linen Service	8.00	176,473	0	176,473	14,009.63	12.60	31.00
32.00	Housekeeping	9.00	655,696	0	655,696	58,250.80	11.26	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	741,876	-596,345	145,531	11,475.36	12.68	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	596,345	596,345	47,022.83	12.68	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	846,468	0	846,468	23,703.56	35.71	38.00
39.00	Central Services and Supply	14.00	114,407	0	114,407	6,375.58	17.94	39.00
40.00	Pharmacy	15.00	764,508	-764,508	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	624,175	0	624,175	31,649.71	19.72	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 9/27/2017 1:07 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		22,959,722	0	22,959,722	967,461.14	23.73	1.00
2.00	Excluded area salaries (see instructions)		616,076	0	616,076	20,363.37	30.25	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,343,646	0	22,343,646	947,097.77	23.59	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,872,131	0	3,872,131	87,887.11	44.06	4.00
5.00	Subtotal wage-related costs (see inst.)		5,686,412	0	5,686,412	0.00	25.45	5.00
6.00	Total (sum of lines 3 thru 5)		31,902,189	0	31,902,189	1,034,984.88	30.82	6.00
7.00	Total overhead cost (see instructions)		10,626,719	-758,308	9,868,411	454,318.76	21.72	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 9/27/2017 1:07 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	714,153	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	333,658	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	30,330	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,452,247	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	46,553	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	362,501	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,807,576	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	35,052	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	35,187	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,817,257	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 9/27/2017 1:07 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	2,272,038	5,817,257	1.00
2.00	Hospital	1,975,395	5,817,257	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	296,643	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0120 | Component CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-4 | Date/Time Prepared: 9/27/2017 1:07 pm

Home Health Agency I | PPS

		1.00	
0.00	County	TAZEWELL	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	177	0	691	868	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	354.00	10.00	45.00	409.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.16	0.00	0.16	4.00
5.00	Other Administrative Personnel		0.89	0.00	0.89	5.00
6.00	Direct Nursing Service		3.14	0.00	3.14	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.08	0.00	0.08	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		37900			20.00
20.01			99914			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,686	136	38	35	1,895	21.00
22.00	Skilled Nursing Visit Charges	293,538	23,664	6,612	6,090	329,904	22.00
23.00	Physical Therapy Visits	1,809	63	11	36	1,919	23.00
24.00	Physical Therapy Visit Charges	343,710	11,970	2,090	6,871	364,641	24.00
25.00	Occupational Therapy Visits	750	43	3	22	818	25.00
26.00	Occupational Therapy Visit Charges	144,000	8,256	576	4,224	157,056	26.00
27.00	Speech Pathology Visits	22	0	0	1	23	27.00
28.00	Speech Pathology Visit Charges	4,554	0	0	207	4,761	28.00
29.00	Medical Social Service Visits	1	1	0	0	2	29.00
30.00	Medical Social Service Visit Charges	279	279	0	0	558	30.00
31.00	Home Health Aide Visits	417	51	0	16	484	31.00
32.00	Home Health Aide Visit Charges	32,943	4,029	0	1,264	38,236	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,685	294	52	110	5,141	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	819,024	48,198	9,278	18,656	895,156	35.00
36.00	Total Number of Episodes (standard/non outlier)	229		20	6	255	36.00
37.00	Total Number of Outlier Episodes		8		1	9	37.00
38.00	Total Non-Routine Medical Supply Charges	8,216	910	421	234	9,781	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet S-10 | Date/Time Prepared: 9/27/2017 1:07 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)	0.276079	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,205,191	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	4,975,136	5.00
6.00	Medicaid charges	49,499,870	6.00
7.00	Medicaid cost (line 1 times line 6)	13,665,875	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)	3,485,548	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,485,548	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	388,457	384,268	772,725	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	107,245	106,088	213,333	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)	107,245	106,088	213,333	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,768,405	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	158,676	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,609,729	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,548,728	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,762,061	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,247,609	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,467,222	1,467,222	400,944	1,868,166	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,439,738	2,439,738	46,342	2,486,080	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,852,268	5,852,268	596,926	6,449,194	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,505,057	13,493,259	18,998,316	-1,161,999	17,836,317	5.00
7.00	00700	OPERATION OF PLANT	586,509	1,624,567	2,211,076	10,825	2,221,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	176,473	76,950	253,423	0	253,423	8.00
9.00	00900	HOUSEKEEPING	655,696	383,717	1,039,413	0	1,039,413	9.00
10.00	01000	DIETARY	741,876	796,231	1,538,107	-1,236,383	301,724	10.00
11.00	01100	CAFETERIA	0	0	0	1,236,383	1,236,383	11.00
13.00	01300	NURSING ADMINISTRATION	846,468	116,559	963,027	-224	962,803	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	114,407	298,335	412,742	-227,213	185,529	14.00
15.00	01500	PHARMACY	764,508	2,049,324	2,813,832	-2,491,992	321,840	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	624,175	194,969	819,144	0	819,144	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,597,382	1,070,212	5,667,594	-1,230,291	4,437,303	30.00
31.00	03100	INTENSIVE CARE UNIT	909,871	148,355	1,058,226	20,327	1,078,553	31.00
43.00	04300	NURSERY	0	0	0	268,671	268,671	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,254,681	4,426,002	6,680,683	-3,830,899	2,849,784	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	755,788	755,788	52.00
53.00	05300	ANESTHESIOLOGY	0	1,446,545	1,446,545	-158,392	1,288,153	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,264,590	334,289	1,598,879	75,038	1,673,917	54.00
56.00	05600	RADIOISOTOPE	149,671	258,930	408,601	-2,516	406,085	56.00
57.00	05700	CT SCAN	230,626	214,961	445,587	20,175	465,762	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	146,663	54,716	201,379	6,193	207,572	58.00
59.00	05900	CARDIAC CATHETERIZATION	220,095	691,187	911,282	-616,596	294,686	59.00
60.00	06000	LABORATORY	1,034,403	1,211,770	2,246,173	-96,858	2,149,315	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	301,309	301,309	85,680	386,989	63.00
65.00	06500	RESPIRATORY THERAPY	359,057	80,625	439,682	-51,658	388,024	65.00
66.00	06600	PHYSICAL THERAPY	0	763,107	763,107	-1,395	761,712	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	112,215	112,215	-158	112,057	67.00
68.00	06800	SPEECH PATHOLOGY	0	45,143	45,143	321	45,464	68.00
69.00	06900	ELECTROCARDIOLOGY	156,351	295,657	452,008	7,239	459,247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,701,192	3,701,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,287,221	2,287,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,530,855	2,530,855	73.00
76.00	03610	SLEEP LAB	0	224,469	224,469	-6,149	218,320	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	455,100	987,596	1,442,696	-340,158	1,102,538	90.00
91.00	09100	EMERGENCY	2,027,723	4,416,085	6,443,808	-261,954	6,181,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	597,464	436,555	1,034,019	-9,364	1,024,655	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		325,921	325,921	-325,921	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,418,846	46,638,788	71,057,634	0	71,057,634	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,612	1,508	20,120	0	20,120	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	24,437,458	46,640,296	71,077,754	0	71,077,754	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A | Date/Time Prepared: 9/27/2017 1:07 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	-3,749	1,864,417		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-6,890	2,479,190		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-794,137	5,655,057		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,061,868	12,774,449		5.00
7.00	00700	OPERATION OF PLANT	0	2,221,901		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	253,423		8.00
9.00	00900	HOUSEKEEPING	-68,733	970,680		9.00
10.00	01000	DIETARY	0	301,724		10.00
11.00	01100	CAFETERIA	-502,929	733,454		11.00
13.00	01300	NURSING ADMINISTRATION	-23,234	939,569		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-134,752	50,777		14.00
15.00	01500	PHARMACY	-338	321,502		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,494	817,650		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-666	4,436,637		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,078,553		31.00
43.00	04300	NURSERY	-437	268,234		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,849,784		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	755,788		52.00
53.00	05300	ANESTHESIOLOGY	-1,288,153	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,260	1,669,657		54.00
56.00	05600	RADIOISOTOPE	0	406,085		56.00
57.00	05700	CT SCAN	0	465,762		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	207,572		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	294,686		59.00
60.00	06000	LABORATORY	-67,500	2,081,815		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	386,989		63.00
65.00	06500	RESPIRATORY THERAPY	0	388,024		65.00
66.00	06600	PHYSICAL THERAPY	-9,319	752,393		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	112,057		67.00
68.00	06800	SPEECH PATHOLOGY	0	45,464		68.00
69.00	06900	ELECTROCARDIOLOGY	-282,082	177,165		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,701,192		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,287,221		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,530,855		73.00
76.00	03610	SLEEP LAB	-101,150	117,170		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-11,608	1,090,930		90.00
91.00	09100	EMERGENCY	0	6,181,854		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-298	1,024,357		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,363,597	62,694,037		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,120		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	VACANT SPACE	0	0		194.00
194.01	07951	LEASED SPACE	0	0		194.01
194.02	07952	FOUNDATION	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,363,597	62,714,157		200.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 9/27/2017 1:07 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	596,345	640,038	1.00
	0		596,345	640,038	
	B - TO RECLASS BLOOD SALARIES FROM LAB				
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	85,725	0	1.00
	0		85,725	0	
	C - TO RECLASS LDR EXPENSES				
1.00	NURSERY	43.00	259,869	6,006	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	731,027	16,894	2.00
	0		990,896	22,900	
	D - TO RECLASS CLINICAL ENGINEERING EXPE				
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,204	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	9,349	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	22,317	3.00
4.00	NURSERY	43.00	0	2,732	4.00
5.00	OPERATING ROOM	50.00	0	93,799	5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,686	6.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	116,782	8.00
9.00	RADIOISOTOPE	56.00	0	188	9.00
10.00	CT SCAN	57.00	0	70,355	10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	54,690	11.00
12.00	LABORATORY	60.00	0	26,785	12.00
13.00	RESPIRATORY THERAPY	65.00	0	17,524	13.00
14.00	PHYSICAL THERAPY	66.00	0	1,077	14.00
15.00	SPEECH PATHOLOGY	68.00	0	321	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	9,046	16.00
17.00	CLINIC	90.00	0	220	17.00
18.00	EMERGENCY	91.00	0	10,940	18.00
19.00	HOME HEALTH AGENCY	101.00	0	131	19.00
	0		0	446,146	
	E - TO RECLASS SUPPLY COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,701,192	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,287,221	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
7.00		0.00	0	0	7.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	5,988,413	
	F - TO RECLASS BILLABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,802,905	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	0		0	1,802,905	
	G - TO RECLASS TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,108	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 9/27/2017 1:07 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	0		0	6,108	
	H - TO RECLASS HUMAN RESOURCES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	224,743	372,183	1.00
	0		224,743	372,183	
	I - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	325,921	1.00
	0		0	325,921	
	J - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	121,365	1.00
	0		0	121,365	
	K - TO RECLASS MRI LEASE EXPENSE				
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	9,870	1.00
	0		0	9,870	
	L - TO RECLASS MRI BUILDING UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	10,825	1.00
	0		0	10,825	
	M - TO RECLASS PHARMACY SALARIES				
1.00	ADMINISTRATIVE & GENERAL	5.00	6,200	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	823	0	2.00
3.00	NURSERY	43.00	64	0	3.00
4.00	OPERATING ROOM	50.00	14,531	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	181	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	4,806	0	6.00
7.00	RADIOISOTOPE	56.00	38	0	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	8,794	0	8.00
9.00	CARDIAC CATHETERIZATION	59.00	124	0	9.00
10.00	LABORATORY	60.00	21	0	10.00
11.00	RESPIRATORY THERAPY	65.00	101	0	11.00
12.00	DRUGS CHARGED TO PATIENTS	73.00	727,950	0	12.00
13.00	SLEEP LAB	76.00	222	0	13.00
14.00	EMERGENCY	91.00	653	0	14.00
	0		764,508	0	
	N - TO RECLASS ANESTHESIOLOGY EXPENSE				
1.00	OPERATING ROOM	50.00	0	158,392	1.00
	0		0	158,392	
500.00	Grand Total: Increases		2,662,217	9,905,066	500.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 9/27/2017 1:07 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	596,345	640,038	0		1.00
	0		596,345	640,038			
	B - TO RECLASS BLOOD SALARIES FROM LAB						
1.00	LABORATORY	60.00	85,725	0	0		1.00
	0		85,725	0			
	C - TO RECLASS LDR EXPENSES						
1.00	ADULTS & PEDIATRICS	30.00	990,896	22,900	0		1.00
2.00		0.00	0	0	0		2.00
	0		990,896	22,900			
	D - TO RECLASS CLINICAL ENGINEERING EXPE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	446,146	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
	0		0	446,146			
	E - TO RECLASS SUPPLY COSTS						
1.00	NURSING ADMINISTRATION	13.00	0	224	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	211,451	0		2.00
3.00	PHARMACY	15.00	0	10,901	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	226,649	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	1,990	0		5.00
7.00	OPERATING ROOM	50.00	0	4,088,166	0		7.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	45,459	0		9.00
10.00	RADIOISOTOPE	56.00	0	2,742	0		10.00
11.00	CT SCAN	57.00	0	43,784	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,252	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	671,406	0		13.00
14.00	LABORATORY	60.00	0	34,019	0		14.00
15.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	45	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	69,282	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,472	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	158	0		18.00
20.00	ELECTROCARDIOLOGY	69.00	0	1,804	0		20.00
21.00	SLEEP LAB	76.00	0	6,371	0		21.00
22.00	CLINIC	90.00	0	297,521	0		22.00
23.00	EMERGENCY	91.00	0	263,935	0		23.00
24.00	HOME HEALTH AGENCY	101.00	0	8,782	0		24.00
	0		0	5,988,413			
	F - TO RECLASS BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	17,966	0		1.00
2.00	PHARMACY	15.00	0	1,716,583	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	18	0		3.00
6.00	OPERATING ROOM	50.00	0	9,455	0		6.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10	0		8.00
10.00	CT SCAN	57.00	0	6,396	0		10.00
12.00	CARDIAC CATHETERIZATION	59.00	0	4	0		12.00
14.00	RESPIRATORY THERAPY	65.00	0	1	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	3	0		15.00
16.00	CLINIC	90.00	0	42,857	0		16.00
17.00	EMERGENCY	91.00	0	9,612	0		17.00
	0		0	1,802,905			
	G - TO RECLASS TELEPHONE EXPENSE						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,081	0		1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	394	0		2.00
3.00	LABORATORY	60.00	0	3,920	0		3.00
4.00	HOME HEALTH AGENCY	101.00	0	713	0		4.00

RECLASSIFICATIONS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-6 | Date/Time Prepared: 9/27/2017 1:07 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	0		0	6,108			
	H - TO RECLASS HUMAN RESOURCES						
1.00	ADMINISTRATIVE & GENERAL	5.00	224,743	372,183	0		1.00
	0		224,743	372,183			
	I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	325,921	11		1.00
	0		0	325,921			
	J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	121,365	0		1.00
	0		0	121,365			
	K - TO RECLASS MRI LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,870	0		1.00
	0		0	9,870			
	L - TO RECLASS MRI BUILDING UTILITIES						
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10,825	0		1.00
	0		0	10,825			
	M - TO RECLASS PHARMACY SALARIES						
1.00	PHARMACY	15.00	764,508	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
	0		764,508	0			
	N - TO RECLASS ANESTHESIOLOGY EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	158,392	0		1.00
	0		0	158,392			
500.00	Grand Total: Decreases		2,662,217	9,905,066			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 9/27/2017 1:07 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,449,581	0	0	0	0	1.00
2.00	Land Improvements	1,827,216	0	0	0	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	0	0	0	3.00
4.00	Building Improvements	20,362,006	683,913	0	683,913	0	4.00
5.00	Fixed Equipment	19,114,647	317,830	0	317,830	0	5.00
6.00	Movable Equipment	33,375,928	1,285,513	0	1,285,513	472,732	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	87,715,324	2,287,256	0	2,287,256	472,732	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	87,715,324	2,287,256	0	2,287,256	472,732	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,449,581	0	1.00
2.00	Land Improvements	1,827,216	5,011	2.00
3.00	Buildings and Fixtures	11,585,946	0	3.00
4.00	Building Improvements	21,045,919	543,175	4.00
5.00	Fixed Equipment	19,432,477	103,789	5.00
6.00	Movable Equipment	34,188,709	2,861,687	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	89,529,848	3,513,662	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	89,529,848	3,513,662	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 9/27/2017 1:07 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,418,888	102	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,439,738	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,858,626	102	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	48,232	1,467,222	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,439,738	2.00
3.00	Total (sum of lines 1-2)	48,232	3,906,960	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 9/27/2017 1:07 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	55,341,139	0	55,341,139	0.618156	75,023	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,188,709	3,663	34,185,046	0.381844	46,342	2.00
3.00	Total (sum of lines 1-2)	89,529,848	3,663	89,526,185	1.000000	121,365	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	75,023	1,418,888	102	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	46,342	2,432,848	0	2.00
3.00	Total (sum of lines 1-2)	0	0	121,365	3,851,736	102	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	322,172	75,023	0	48,232	1,864,417	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	46,342	0	0	2,479,190	2.00
3.00	Total (sum of lines 1-2)	322,172	121,365	0	48,232	4,343,607	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8 | Date/Time Prepared: 9/27/2017 1:07 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	-3,749	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-459,215			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-4,477,455			0	12.00
13.00	Laundry and linen service	B	-68,733	HOUSEKEEPING	9.00	0	13.00
14.00	Cafeteria-employees and guests	B	-367,653	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	-1,494	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADMIN FEE FLEX	B	-179	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MOW & CATERING	B	-135,276	CAFETERIA	11.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8 | Date/Time Prepared: 9/27/2017 1:07 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	
33.03	PAIN MANAGEMENT	B	-81,521	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICAL THERAPY OTHER INCOME	B	-9,319	PHYSICAL THERAPY	66.00	0	33.04
33.05	EDUCATION REVENUE	B	-14,515	NURSING ADMINISTRATION	13.00	0	33.05
33.06	SICKBAY REVENUE	B	-400	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	RADIOLOGY TRANSCRIPT REVENUE	B	-4,163	RADIOLOGY-DIAGNOSTIC	54.00	0	33.07
33.08	NURSERY OTHER INCOME	B	-437	NURSERY	43.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-71	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PURCHASE DISCOUNTS	B	-134,752	CENTRAL SERVICES & SUPPLY	14.00	0	33.10
33.11	FEDERAL EXCISE TAX	B	-338	PHARMACY	15.00	0	33.11
33.12	ADVERSTISING SALARY EXPENSE	A	-136,973	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	ADVERTISING EXPENSE	A	-393,385	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	ADVERTISING BENEFITS	A	-23,296	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	CRNA - PURCHASED SERVICES	A	-1,288,153	ANESTHESIOLOGY	53.00	0	33.15
33.16	SELF INSURANCE EXPENSE	A	-770,584	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	HEALTHLINK ADMIN FEES	A	30,204	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	MARKETING SUPPLIES	A	-298	HOME HEALTH AGENCY	101.00	0	33.18
33.19	PROMOTIONS	A	-4,152	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	PUBLIC RELATIONS	A	-5,483	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	PUBLIC RELATIONS	A	-236	NURSING ADMINISTRATION	13.00	0	33.21
33.22	PUBLIC RELATIONS	A	-266	ADULTS & PEDIATRICS	30.00	0	33.22
33.23	PUBLIC RELATIONS	A	-97	RADIOLOGY-DIAGNOSTIC	54.00	0	33.23
33.24	PUBLIC RELATIONS	A	-11,608	CLINIC	90.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,363,597				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 9/27/2017 1:07 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL REL COSTS- MME	1,150,812	1,157,702	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE/FINANCE/IS	5,971,803	7,405,600	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PROVIDER TAX HOSPITAL	0	3,036,511	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HUMAN RESOURCES	596,669	596,926	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,719,284	12,196,739	5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet A-8-1 Date/Time Prepared: 9/27/2017 1:07 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-6,890	9		1.00
2.00	-1,433,797	0		2.00
3.00	-3,036,511	0		3.00
4.00	-257	0		4.00
5.00	-4,477,455			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 9/27/2017 1:07 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	76.00	SLEEP LAB	101,150	101,150	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	8,483	8,483	0	0	0	2.00
3.00	60.00	LABORATORY	67,500	67,500	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	293,476	281,476	12,000	197,500	120	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			470,609	458,609	12,000		120	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	76.00	SLEEP LAB	0	0	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	11,394	570	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			11,394	570	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	76.00	SLEEP LAB	0	0	0	101,150		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	8,483		2.00
3.00	60.00	LABORATORY	0	0	0	67,500		3.00
4.00	0.00		0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	11,394	606	282,082		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	11,394	606	459,215		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,864,417	1,864,417				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,479,190		2,479,190			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,655,057	7,543	959,838	6,622,438		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,774,449	620,014	23,101	1,416,463	14,834,027	5.00
7.00	00700	OPERATION OF PLANT	2,221,901	255,299	23,539	161,329	2,662,068	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	253,423	19,122	6,425	48,542	327,512	8.00
9.00	00900	HOUSEKEEPING	970,680	1,519	5,939	180,360	1,158,498	9.00
10.00	01000	DIETARY	301,724	36,404	24,339	40,031	402,498	10.00
11.00	01100	CAFETERIA	733,454	10,183	40,553	164,035	948,225	11.00
13.00	01300	NURSING ADMINISTRATION	939,569	49,160	68,698	232,835	1,290,262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,777	26,501	5,614	31,470	114,362	14.00
15.00	01500	PHARMACY	321,502	8,766	1,306	0	331,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	817,650	21,904	0	171,690	1,011,244	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,436,637	211,052	81,861	992,259	5,721,809	30.00
31.00	03100	INTENSIVE CARE UNIT	1,078,553	20,314	59,176	250,275	1,408,318	31.00
43.00	04300	NURSERY	268,234	5,280	5,469	71,497	350,480	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,849,784	106,168	373,497	624,185	3,953,634	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	755,788	17,124	15,384	201,127	989,423	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,669,657	79,769	394,196	349,169	2,492,791	54.00
56.00	05600	RADIOISOTOPE	406,085	4,459	1,620	41,180	453,344	56.00
57.00	05700	CT SCAN	465,762	3,924	2,920	63,438	536,044	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	207,572	10,356	185,274	42,761	445,963	58.00
59.00	05900	CARDIAC CATHETERIZATION	294,686	3,899	32,251	60,575	391,411	59.00
60.00	06000	LABORATORY	2,081,815	30,675	52,151	260,956	2,425,597	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	386,989	0	998	23,580	411,567	63.00
65.00	06500	RESPIRATORY THERAPY	388,024	7,777	22,670	98,793	517,264	65.00
66.00	06600	PHYSICAL THERAPY	752,393	20,131	2,108	0	774,632	66.00
67.00	06700	OCCUPATIONAL THERAPY	112,057	2,446	42	0	114,545	67.00
68.00	06800	SPEECH PATHOLOGY	45,464	9,418	0	0	54,882	68.00
69.00	06900	ELECTROCARDIOLOGY	177,165	27,143	43,951	43,007	291,266	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,701,192	0	0	0	3,701,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,287,221	0	0	0	2,287,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,530,855	0	0	200,235	2,731,090	73.00
76.00	03610	SLEEP LAB	117,170	3,771	228	61	121,230	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,090,930	10,300	5,149	125,183	1,231,562	90.00
91.00	09100	EMERGENCY	6,181,854	74,983	31,553	557,939	6,846,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,024,357	12,084	9,328	164,343	1,210,112	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,694,037	1,717,488	2,479,178	6,617,318	62,541,976	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,120	20,324	12	5,120	45,576	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	93,198	0	0	93,198	192.00
194.00	07950	VACANT SPACE	0	5,025	0	0	5,025	194.00
194.01	07951	LEASED SPACE	0	25,854	0	0	25,854	194.01
194.02	07952	FOUNDATION	0	2,528	0	0	2,528	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	62,714,157	1,864,417	2,479,190	6,622,438	62,714,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,834,027					5.00
7.00	00700	OPERATION OF PLANT	824,751	3,486,819				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	101,468	67,926	496,906			8.00
9.00	00900	HOUSEKEEPING	358,921	5,395	34,741	1,557,555		9.00
10.00	01000	DIETARY	124,700	129,317	1,084	59,006	716,605	10.00
11.00	01100	CAFETERIA	293,775	36,172	0	16,505	0	11.00
13.00	01300	NURSING ADMINISTRATION	399,744	174,632	0	79,683	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,431	94,141	23,556	42,956	0	14.00
15.00	01500	PHARMACY	102,727	31,139	0	14,208	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	313,300	77,811	0	35,505	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,772,708	749,723	108,808	342,096	641,867	30.00
31.00	03100	INTENSIVE CARE UNIT	436,319	72,163	68,420	32,927	74,738	31.00
43.00	04300	NURSERY	108,584	18,756	10,320	8,558	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,224,899	377,143	65,442	172,088	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	306,539	60,830	29,031	27,756	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	772,307	283,364	38,522	129,297	0	54.00
56.00	05600	RADIOISOTOPE	140,453	15,841	0	7,228	0	56.00
57.00	05700	CT SCAN	166,075	13,940	0	6,361	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	138,166	36,787	4,657	16,786	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	121,265	13,850	0	6,319	0	59.00
60.00	06000	LABORATORY	751,489	108,968	3,038	49,721	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	127,510	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	160,257	27,627	0	12,606	0	65.00
66.00	06600	PHYSICAL THERAPY	239,993	71,511	8,530	32,630	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,488	8,690	0	3,965	0	67.00
68.00	06800	SPEECH PATHOLOGY	17,003	33,456	0	15,266	0	68.00
69.00	06900	ELECTROCARDIOLOGY	90,239	96,422	0	43,997	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,146,689	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	708,618	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	846,135	0	0	0	0	73.00
76.00	03610	SLEEP LAB	37,559	13,397	0	6,113	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	381,558	36,588	16	16,695	0	90.00
91.00	09100	EMERGENCY	2,121,101	266,365	90,595	121,540	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	374,912	42,925	0	19,586	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,780,683	2,964,879	486,760	1,319,398	716,605	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,120	72,199	0	32,944	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,874	331,068	10,146	151,064	0	192.00
194.00	07950	VACANT SPACE	1,557	17,851	0	8,145	0	194.00
194.01	07951	LEASED SPACE	8,010	91,842	0	41,907	0	194.01
194.02	07952	FOUNDATION	783	8,980	0	4,097	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,834,027	3,486,819	496,906	1,557,555	716,605	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,294,677					11.00
13.00	01300	NURSING ADMINISTRATION	50,782	1,995,103				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,676	0	324,122			14.00
15.00	01500	PHARMACY	0	0	472	480,120		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,799	0	353	0	1,506,012	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	311,464	1,681,913	2,063	521	894,971	30.00
31.00	03100	INTENSIVE CARE UNIT	69,803	189,549	131	0	43,494	31.00
43.00	04300	NURSERY	18,219	123,641	80	41	65,526	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	175,466	0	5,829	9,200	321,876	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,183	0	226	115	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	108,335	0	667	3,043	0	54.00
56.00	05600	RADIOISOTOPE	8,107	0	11	24	0	56.00
57.00	05700	CT SCAN	17,106	0	53	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,849	0	74	5,568	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,408	0	188	78	0	59.00
60.00	06000	LABORATORY	87,666	0	1,202	13	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,796	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	31,583	0	155	64	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	159	0	123,121	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,898	0	107	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	191,400	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	118,277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,962	0	0	460,898	0	73.00
76.00	03610	SLEEP LAB	0	0	115	141	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	43,699	0	603	0	0	90.00
91.00	09100	EMERGENCY	147,090	0	1,694	414	57,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	185	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,290,891	1,995,103	324,044	480,120	1,506,012	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,786	0	78	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,294,677	1,995,103	324,122	480,120	1,506,012	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part I | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	12,227,943	0	12,227,943		30.00
31.00	03100	INTENSIVE CARE UNIT	2,395,862	0	2,395,862		31.00
43.00	04300	NURSERY	704,205	0	704,205		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,305,577	0	6,305,577		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,465,103	0	1,465,103		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,828,326	0	3,828,326		54.00
56.00	05600	RADIOISOTOPE	625,008	0	625,008		56.00
57.00	05700	CT SCAN	739,579	0	739,579		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	659,850	0	659,850		58.00
59.00	05900	CARDIAC CATHETERIZATION	546,519	0	546,519		59.00
60.00	06000	LABORATORY	3,427,694	0	3,427,694		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	546,873	0	546,873		63.00
65.00	06500	RESPIRATORY THERAPY	749,556	0	749,556		65.00
66.00	06600	PHYSICAL THERAPY	1,250,576	0	1,250,576		66.00
67.00	06700	OCCUPATIONAL THERAPY	162,688	0	162,688		67.00
68.00	06800	SPEECH PATHOLOGY	120,607	0	120,607		68.00
69.00	06900	ELECTROCARDIOLOGY	535,929	0	535,929		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,039,281	0	5,039,281		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,114,116	0	3,114,116		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,080,085	0	4,080,085		73.00
76.00	03610	SLEEP LAB	178,555	0	178,555		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,710,721	0	1,710,721		90.00
91.00	09100	EMERGENCY	9,652,152	0	9,652,152		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,647,720	0	1,647,720		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,714,525	0	61,714,525		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168,703	0	168,703		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	614,350	0	614,350		192.00
194.00	07950	VACANT SPACE	32,578	0	32,578		194.00
194.01	07951	LEASED SPACE	167,613	0	167,613		194.01
194.02	07952	FOUNDATION	16,388	0	16,388		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	62,714,157	0	62,714,157		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/27/2017 1:07 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	7,543	959,838	967,381	967,381	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,201	620,014	23,101	679,316	206,905	5.00
7.00	00700	OPERATION OF PLANT	7,062	255,299	23,539	285,900	23,567	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,122	6,425	25,547	7,091	8.00
9.00	00900	HOUSEKEEPING	0	1,519	5,939	7,458	26,347	9.00
10.00	01000	DIETARY	0	36,404	24,339	60,743	5,848	10.00
11.00	01100	CAFETERIA	0	10,183	40,553	50,736	23,962	11.00
13.00	01300	NURSING ADMINISTRATION	0	49,160	68,698	117,858	34,012	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,850	26,501	5,614	35,965	4,597	14.00
15.00	01500	PHARMACY	192,906	8,766	1,306	202,978	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,904	0	21,904	25,080	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,464	211,052	81,861	315,377	144,946	30.00
31.00	03100	INTENSIVE CARE UNIT	6,962	20,314	59,176	86,452	36,560	31.00
43.00	04300	NURSERY	0	5,280	5,469	10,749	10,444	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	106,168	373,497	479,665	91,179	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,124	15,384	32,508	29,380	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,845	79,769	394,196	512,810	51,006	54.00
56.00	05600	RADIOISOTOPE	0	4,459	1,620	6,079	6,015	56.00
57.00	05700	CT SCAN	0	3,924	2,920	6,844	9,267	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,870	10,356	185,274	205,500	6,246	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,899	32,251	36,150	8,849	59.00
60.00	06000	LABORATORY	0	30,675	52,151	82,826	38,120	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	998	998	3,445	63.00
65.00	06500	RESPIRATORY THERAPY	1,843	7,777	22,670	32,290	14,431	65.00
66.00	06600	PHYSICAL THERAPY	0	20,131	2,108	22,239	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,446	42	2,488	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,418	0	9,418	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,143	43,951	71,094	6,282	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	29,250	73.00
76.00	03610	SLEEP LAB	0	3,771	228	3,999	9	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,300	5,149	15,449	18,286	90.00
91.00	09100	EMERGENCY	0	74,983	31,553	106,536	81,502	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	14,034	12,084	9,328	35,446	24,007	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	334,037	1,717,488	2,479,178	4,530,703	966,633	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,324	12	20,336	748	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	93,198	0	93,198	0	192.00
194.00	07950	VACANT SPACE	0	5,025	0	5,025	0	194.00
194.01	07951	LEASED SPACE	0	25,854	0	25,854	0	194.01
194.02	07952	FOUNDATION	0	2,528	0	2,528	0	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	334,037	1,864,417	2,479,190	4,677,644	967,381	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	886,221					5.00
7.00	00700	OPERATION OF PLANT	49,272	358,739				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,062	6,989	45,689			8.00
9.00	00900	HOUSEKEEPING	21,443	555	3,194	58,997		9.00
10.00	01000	DIETARY	7,450	13,305	100	2,235	89,681	10.00
11.00	01100	CAFETERIA	17,551	3,722	0	625	0	11.00
13.00	01300	NURSING ADMINISTRATION	23,881	17,967	0	3,018	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,117	9,686	2,166	1,627	0	14.00
15.00	01500	PHARMACY	6,137	3,204	0	538	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,717	8,006	0	1,345	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	105,905	77,134	10,005	12,959	80,328	30.00
31.00	03100	INTENSIVE CARE UNIT	26,067	7,424	6,291	1,247	9,353	31.00
43.00	04300	NURSERY	6,487	1,930	949	324	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,178	38,802	6,017	6,518	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,313	6,258	2,669	1,051	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,139	29,154	3,542	4,898	0	54.00
56.00	05600	RADIOISOTOPE	8,391	1,630	0	274	0	56.00
57.00	05700	CT SCAN	9,922	1,434	0	241	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,254	3,785	428	636	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,245	1,425	0	239	0	59.00
60.00	06000	LABORATORY	44,895	11,211	279	1,883	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,618	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,574	2,842	0	477	0	65.00
66.00	06600	PHYSICAL THERAPY	14,338	7,357	784	1,236	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,120	894	0	150	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,016	3,442	0	578	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,391	9,920	0	1,667	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	68,505	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	42,334	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,550	0	0	0	0	73.00
76.00	03610	SLEEP LAB	2,244	1,378	0	232	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,795	3,764	2	632	0	90.00
91.00	09100	EMERGENCY	126,724	27,405	8,330	4,604	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	22,398	4,416	0	742	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	883,033	305,039	44,756	49,976	89,681	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	844	7,428	0	1,248	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,725	34,062	933	5,722	0	192.00
194.00	07950	VACANT SPACE	93	1,837	0	309	0	194.00
194.01	07951	LEASED SPACE	479	9,449	0	1,587	0	194.01
194.02	07952	FOUNDATION	47	924	0	155	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	886,221	358,739	45,689	58,997	89,681	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	96,596					11.00
13.00	01300	NURSING ADMINISTRATION	3,789	200,525				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,020	0	57,178			14.00
15.00	01500	PHARMACY	0	0	83	212,940		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,058	0	62	0	80,172	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,239	169,047	364	231	47,644	30.00
31.00	03100	INTENSIVE CARE UNIT	5,208	19,051	23	0	2,315	31.00
43.00	04300	NURSERY	1,359	12,427	14	18	3,488	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,092	0	1,028	4,080	17,135	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,819	0	40	51	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,083	0	118	1,349	0	54.00
56.00	05600	RADIOISOTOPE	605	0	2	11	0	56.00
57.00	05700	CT SCAN	1,276	0	9	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	884	0	13	2,469	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,000	0	33	35	0	59.00
60.00	06000	LABORATORY	6,541	0	212	6	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	582	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,356	0	27	28	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	28	0	6,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,037	0	19	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	33,765	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	20,866	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,131	0	0	204,417	0	73.00
76.00	03610	SLEEP LAB	0	0	20	62	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,260	0	106	0	0	90.00
91.00	09100	EMERGENCY	10,974	0	299	183	3,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	33	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,313	200,525	57,164	212,940	80,172	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	283	0	14	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	VACANT SPACE	0	0	0	0	0	194.00
194.01	07951	LEASED SPACE	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	96,596	200,525	57,178	212,940	80,172	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B Part II | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	987,179	0	987,179		30.00
31.00	03100	INTENSIVE CARE UNIT	199,991	0	199,991		31.00
43.00	04300	NURSERY	48,189	0	48,189		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	730,694	0	730,694		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94,089	0	94,089		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	657,099	0	657,099		54.00
56.00	05600	RADIOISOTOPE	23,007	0	23,007		56.00
57.00	05700	CT SCAN	28,993	0	28,993		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,215	0	228,215		58.00
59.00	05900	CARDIAC CATHETERIZATION	54,976	0	54,976		59.00
60.00	06000	LABORATORY	185,973	0	185,973		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,643	0	12,643		63.00
65.00	06500	RESPIRATORY THERAPY	62,025	0	62,025		65.00
66.00	06600	PHYSICAL THERAPY	52,536	0	52,536		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,652	0	5,652		67.00
68.00	06800	SPEECH PATHOLOGY	14,454	0	14,454		68.00
69.00	06900	ELECTROCARDIOLOGY	95,410	0	95,410		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,270	0	102,270		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,200	0	63,200		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,348	0	287,348		73.00
76.00	03610	SLEEP LAB	7,944	0	7,944		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	64,294	0	64,294		90.00
91.00	09100	EMERGENCY	369,593	0	369,593		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	87,042	0	87,042		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,462,816	0	4,462,816		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,901	0	30,901		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	135,640	0	135,640		192.00
194.00	07950	VACANT SPACE	7,264	0	7,264		194.00
194.01	07951	LEASED SPACE	37,369	0	37,369		194.01
194.02	07952	FOUNDATION	3,654	0	3,654		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,677,644	0	4,677,644		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	365,831					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,216,870				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,480	858,278	24,075,743			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	121,658	20,657	5,149,541	-14,834,027	47,880,130	5.00
7.00	00700	OPERATION OF PLANT	50,094	21,048	586,509	0	2,662,068	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	5,745	176,473	0	327,512	8.00
9.00	00900	HOUSEKEEPING	298	5,311	655,696	0	1,158,498	9.00
10.00	01000	DIETARY	7,143	21,764	145,531	0	402,498	10.00
11.00	01100	CAFETERIA	1,998	36,262	596,345	0	948,225	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	61,429	846,468	0	1,290,262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	5,020	114,407	0	114,362	14.00
15.00	01500	PHARMACY	1,720	1,168	0	0	331,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	0	624,175	0	1,011,244	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	73,199	3,607,334	0	5,721,809	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	52,915	909,871	0	1,408,318	31.00
43.00	04300	NURSERY	1,036	4,890	259,925	0	350,480	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	333,978	2,269,212	0	3,953,634	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	13,756	731,192	0	989,423	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	352,487	1,269,396	0	2,492,791	54.00
56.00	05600	RADIOISOTOPE	875	1,449	149,709	0	453,344	56.00
57.00	05700	CT SCAN	770	2,611	230,626	0	536,044	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	165,670	155,457	0	445,963	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	28,839	220,219	0	391,411	59.00
60.00	06000	LABORATORY	6,019	46,633	948,699	0	2,425,597	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	892	85,725	0	411,567	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	20,271	359,158	0	517,264	65.00
66.00	06600	PHYSICAL THERAPY	3,950	1,885	0	0	774,632	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	38	0	0	114,545	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	0	0	54,882	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	39,301	156,351	0	291,266	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,701,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,287,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	727,950	0	2,731,090	73.00
76.00	03610	SLEEP LAB	740	204	222	0	121,230	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	4,604	455,100	0	1,231,562	90.00
91.00	09100	EMERGENCY	14,713	28,214	2,028,376	0	6,846,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,371	8,341	597,464	0	1,210,112	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	337,001	2,216,859	24,057,131	-14,834,027	47,707,949	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	11	18,612	0	45,576	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	0	0	93,198	192.00
194.00	07950	VACANT SPACE	986	0	0	0	5,025	194.00
194.01	07951	LEASED SPACE	5,073	0	0	0	25,854	194.01
194.02	07952	FOUNDATION	496	0	0	0	2,528	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,864,417	2,479,190	6,622,438		14,834,027	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.096389	1.118329	0.275067		0.309816	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			967,381		886,221	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.040181		0.018509	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	192,599					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	607,192				8.00
9.00	00900	HOUSEKEEPING	298	42,452	188,549			9.00
10.00	01000	DIETARY	7,143	1,325	7,143	47,174		10.00
11.00	01100	CAFETERIA	1,998	0	1,998	0	29,064	11.00
13.00	01300	NURSING ADMINISTRATION	9,646	0	9,646	0	1,140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	28,784	5,200	0	307	14.00
15.00	01500	PHARMACY	1,720	0	1,720	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,298	0	4,298	0	1,522	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,412	132,957	41,412	42,254	6,992	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	83,605	3,986	4,920	1,567	31.00
43.00	04300	NURSERY	1,036	12,611	1,036	0	409	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,832	79,967	20,832	0	3,939	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	35,474	3,360	0	1,149	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	47,072	15,652	0	2,432	54.00
56.00	05600	RADIOISOTOPE	875	0	875	0	182	56.00
57.00	05700	CT SCAN	770	0	770	0	384	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	5,690	2,032	0	266	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	0	765	0	301	59.00
60.00	06000	LABORATORY	6,019	3,712	6,019	0	1,968	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	175	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	0	1,526	0	709	65.00
66.00	06600	PHYSICAL THERAPY	3,950	10,423	3,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	0	480	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	1,848	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	0	5,326	0	312	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	942	73.00
76.00	03610	SLEEP LAB	740	0	740	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,021	20	2,021	0	981	90.00
91.00	09100	EMERGENCY	14,713	110,702	14,713	0	3,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,371	0	2,371	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	163,769	594,794	159,719	47,174	28,979	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	3,988	0	85	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	12,398	18,287	0	0	192.00
194.00	07950	VACANT SPACE	986	0	986	0	0	194.00
194.01	07951	LEASED SPACE	5,073	0	5,073	0	0	194.01
194.02	07952	FOUNDATION	496	0	496	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,486,819	496,906	1,557,555	716,605	1,294,677	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.104035	0.818367	8.260744	15.190677	44.545727	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	358,739	45,689	58,997	89,681	96,596	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.862621	0.075246	0.312900	1.901068	3.323562	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet B-1 | Date/Time Prepared: 9/27/2017 1:07 pm

		Cost Center Description	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	11,957					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,267,788				14.00
15.00	01500	PHARMACY	0	9,134	1,878,092			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,835	0	29,051		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,080	39,893	2,039	17,264		30.00
31.00	03100	INTENSIVE CARE UNIT	1,136	2,536	0	839		31.00
43.00	04300	NURSERY	741	1,556	159	1,264		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	112,720	35,988	6,209		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,378	449	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,889	11,902	0		54.00
56.00	05600	RADIOISOTOPE	0	222	93	0		56.00
57.00	05700	CT SCAN	0	1,032	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,438	21,779	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,632	307	0		59.00
60.00	06000	LABORATORY	0	23,245	51	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	3,000	251	0		65.00
66.00	06600	PHYSICAL THERAPY	0	3,081	0	2,375		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	1	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,077	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,701,192	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,287,221	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,802,905	0		73.00
76.00	03610	SLEEP LAB	0	2,217	551	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,653	0	0		90.00
91.00	09100	EMERGENCY	0	32,753	1,618	1,100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	3,575	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,957	6,266,280	1,878,092	29,051		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,508	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	VACANT SPACE	0	0	0	0		194.00
194.01	07951	LEASED SPACE	0	0	0	0		194.01
194.02	07952	FOUNDATION	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,995,103	324,122	480,120	1,506,012		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	166.856486	0.051712	0.255642	51.840281		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	200,525	57,178	212,940	80,172		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	16.770511	0.009123	0.113381	2.759698		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/27/2017 1:07 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,227,943		12,227,943	0	12,227,943	30.00
31.00	03100	INTENSIVE CARE UNIT	2,395,862		2,395,862	0	2,395,862	31.00
43.00	04300	NURSERY	704,205		704,205	0	704,205	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,305,577		6,305,577	0	6,305,577	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,465,103		1,465,103	0	1,465,103	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,828,326		3,828,326	0	3,828,326	54.00
56.00	05600	RADIOISOTOPE	625,008		625,008	0	625,008	56.00
57.00	05700	CT SCAN	739,579		739,579	0	739,579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	659,850		659,850	0	659,850	58.00
59.00	05900	CARDIAC CATHETERIZATION	546,519		546,519	0	546,519	59.00
60.00	06000	LABORATORY	3,427,694		3,427,694	0	3,427,694	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	546,873		546,873	0	546,873	63.00
65.00	06500	RESPIRATORY THERAPY	749,556	0	749,556	0	749,556	65.00
66.00	06600	PHYSICAL THERAPY	1,250,576	0	1,250,576	0	1,250,576	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,688	0	162,688	0	162,688	67.00
68.00	06800	SPEECH PATHOLOGY	120,607	0	120,607	0	120,607	68.00
69.00	06900	ELECTROCARDIOLOGY	535,929		535,929	606	536,535	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,039,281		5,039,281	0	5,039,281	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,114,116		3,114,116	0	3,114,116	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,080,085		4,080,085	0	4,080,085	73.00
76.00	03610	SLEEP LAB	178,555		178,555	0	178,555	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,710,721		1,710,721	0	1,710,721	90.00
91.00	09100	EMERGENCY	9,652,152		9,652,152	0	9,652,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,988,038		1,988,038		1,988,038	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,647,720		1,647,720		1,647,720	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	63,702,563	0	63,702,563	606	63,703,169	200.00
201.00		Less Observation Beds	1,988,038		1,988,038		1,988,038	201.00
202.00		Total (see instructions)	61,714,525	0	61,714,525	606	61,715,131	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/27/2017 1:07 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,727,609		16,727,609			30.00
31.00	03100	INTENSIVE CARE UNIT	3,007,177		3,007,177			31.00
43.00	04300	NURSERY	749,848		749,848			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,996,050	28,733,562	36,729,612	0.171676	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,796,778	313,048	2,109,826	0.694419	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,597,290	14,944,981	17,542,271	0.218234	0.000000	54.00
56.00	05600	RADIOISOTOPE	849,213	4,870,056	5,719,269	0.109281	0.000000	56.00
57.00	05700	CT SCAN	4,889,727	25,910,127	30,799,854	0.024012	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	315,810	5,306,455	5,622,265	0.117364	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	913,330	3,179,335	4,092,665	0.133536	0.000000	59.00
60.00	06000	LABORATORY	1,780,741	4,952,246	6,732,987	0.509090	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	379,417	228,993	608,410	0.898856	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,720,622	293,134	3,013,756	0.248712	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,474,238	2,227,850	3,702,088	0.337803	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	400,176	201,574	601,750	0.270358	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	144,327	147,830	292,157	0.412816	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,653,949	6,259,262	8,913,211	0.060127	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,061,426	2,879,730	7,941,156	0.634578	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,497,424	1,927,073	5,424,497	0.574084	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,390,741	10,851,482	21,242,223	0.192074	0.000000	73.00
76.00	03610	SLEEP LAB	254	1,205,376	1,205,630	0.148101	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,114	4,696,939	4,699,053	0.364057	0.000000	90.00
91.00	09100	EMERGENCY	4,928,179	26,876,777	31,804,956	0.303479	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	317,706	2,604,764	2,922,470	0.680260	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,334,482	1,334,482			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	73,594,146	149,945,076	223,539,222			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	73,594,146	149,945,076	223,539,222			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet C Part I Date/Time Prepared: 9/27/2017 1:07 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.171676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.694419	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218234	54.00
56.00	05600	RADIOISOTOPE	0.109281	56.00
57.00	05700	CT SCAN	0.024012	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117364	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.133536	59.00
60.00	06000	LABORATORY	0.509090	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.898856	63.00
65.00	06500	RESPIRATORY THERAPY	0.248712	65.00
66.00	06600	PHYSICAL THERAPY	0.337803	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270358	67.00
68.00	06800	SPEECH PATHOLOGY	0.412816	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060195	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.634578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.574084	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192074	73.00
76.00	03610	SLEEP LAB	0.148101	76.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.364057	90.00
91.00	09100	EMERGENCY	0.303479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.680260	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part I Date/Time Prepared: 9/27/2017 1:07 pm

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	987,179	0	987,179	12,037	82.01	30.00
31.00	INTENSIVE CARE UNIT	199,991		199,991	1,136	176.05	31.00
43.00	NURSERY	48,189		48,189	741	65.03	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,235,359		1,235,359	13,914		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,383	441,460				30.00
31.00	INTENSIVE CARE UNIT	503	88,553				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30-199)	5,886	530,013				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part II Date/Time Prepared: 9/27/2017 1:07 pm

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	730,694	36,729,612	0.019894	4,268,020	84,908	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	94,089	2,109,826	0.044596	6,129	273	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	657,099	17,542,271	0.037458	1,490,445	55,829	54.00
56.00	05600	RADIOISOTOPE	23,007	5,719,269	0.004023	543,503	2,187	56.00
57.00	05700	CT SCAN	28,993	30,799,854	0.000941	2,663,825	2,507	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	228,215	5,622,265	0.040591	177,820	7,218	58.00
59.00	05900	CARDIAC CATHETERIZATION	54,976	4,092,665	0.013433	554,127	7,444	59.00
60.00	06000	LABORATORY	185,973	6,732,987	0.027621	903,358	24,952	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,643	608,410	0.020780	213,505	4,437	63.00
65.00	06500	RESPIRATORY THERAPY	62,025	3,013,756	0.020581	1,667,346	34,316	65.00
66.00	06600	PHYSICAL THERAPY	52,536	3,702,088	0.014191	935,015	13,269	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,652	601,750	0.009393	265,766	2,496	67.00
68.00	06800	SPEECH PATHOLOGY	14,454	292,157	0.049473	104,716	5,181	68.00
69.00	06900	ELECTROCARDIOLOGY	95,410	8,913,211	0.010704	1,693,697	18,129	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,270	7,941,156	0.012878	2,857,383	36,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,200	5,424,497	0.011651	1,920,167	22,372	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	287,348	21,242,223	0.013527	5,508,850	74,518	73.00
76.00	03610	SLEEP LAB	7,944	1,205,630	0.006589	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	64,294	4,699,053	0.013682	2,114	29	90.00
91.00	09100	EMERGENCY	369,593	31,804,956	0.011621	2,588,888	30,085	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	160,496	2,922,470	0.054918	159,623	8,766	92.00
200.00		Total (lines 50-199)	3,300,911	201,720,106		28,524,297	435,713	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part III Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,037	0.00	5,383	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,136	0.00	503	0		31.00
43.00	04300	NURSERY	741	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	13,914		5,886	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	36,729,612	0.000000	0.000000	4,268,020	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,109,826	0.000000	0.000000	6,129	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,542,271	0.000000	0.000000	1,490,445	54.00
56.00	05600	RADIOISOTOPE	0	5,719,269	0.000000	0.000000	543,503	56.00
57.00	05700	CT SCAN	0	30,799,854	0.000000	0.000000	2,663,825	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,622,265	0.000000	0.000000	177,820	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,092,665	0.000000	0.000000	554,127	59.00
60.00	06000	LABORATORY	0	6,732,987	0.000000	0.000000	903,358	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	608,410	0.000000	0.000000	213,505	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,013,756	0.000000	0.000000	1,667,346	65.00
66.00	06600	PHYSICAL THERAPY	0	3,702,088	0.000000	0.000000	935,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	601,750	0.000000	0.000000	265,766	67.00
68.00	06800	SPEECH PATHOLOGY	0	292,157	0.000000	0.000000	104,716	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,913,211	0.000000	0.000000	1,693,697	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,941,156	0.000000	0.000000	2,857,383	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,424,497	0.000000	0.000000	1,920,167	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,242,223	0.000000	0.000000	5,508,850	73.00
76.00	03610	SLEEP LAB	0	1,205,630	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4,699,053	0.000000	0.000000	2,114	90.00
91.00	09100	EMERGENCY	0	31,804,956	0.000000	0.000000	2,588,888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,922,470	0.000000	0.000000	159,623	92.00
200.00		Total (lines 50-199)	0	201,720,106			28,524,297	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part IV Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,746,355	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	55,403	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,760,878	0		54.00
56.00	05600	RADIOISOTOPE	0	1,810,821	0		56.00
57.00	05700	CT SCAN	0	8,341,794	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,604,744	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,582,909	0		59.00
60.00	06000	LABORATORY	0	691,168	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	151,857	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	96,712	0		65.00
66.00	06600	PHYSICAL THERAPY	0	23,559	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,400	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,346	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,190,337	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	740,923	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	958,544	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,650,811	0		73.00
76.00	03610	SLEEP LAB	0	363,509	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,689,020	0		90.00
91.00	09100	EMERGENCY	0	4,677,842	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	546,870	0		92.00
200.00		Total (lines 50-199)	0	38,692,802	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.171676	6,746,355	0	0	1,158,187	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.694419	55,403	0	0	38,473	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218234	3,760,878	0	0	820,751	54.00
56.00	05600	RADIOISOTOPE	0.109281	1,810,821	0	0	197,888	56.00
57.00	05700	CT SCAN	0.024012	8,341,794	0	0	200,303	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117364	1,604,744	0	0	188,339	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.133536	1,582,909	0	0	211,375	59.00
60.00	06000	LABORATORY	0.509090	691,168	2,224	0	351,867	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.898856	151,857	0	0	136,498	63.00
65.00	06500	RESPIRATORY THERAPY	0.248712	96,712	0	0	24,053	65.00
66.00	06600	PHYSICAL THERAPY	0.337803	23,559	0	0	7,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270358	6,400	0	0	1,730	67.00
68.00	06800	SPEECH PATHOLOGY	0.412816	2,346	0	0	968	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060127	2,190,337	0	0	131,698	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.634578	740,923	0	0	470,173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.574084	958,544	7,625	0	550,285	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192074	2,650,811	0	15,607	509,152	73.00
76.00	03610	SLEEP LAB	0.148101	363,509	0	0	53,836	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.364057	1,689,020	0	0	614,900	90.00
91.00	09100	EMERGENCY	0.303479	4,677,842	0	0	1,419,627	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.680260	546,870	0	0	372,014	92.00
200.00		Subtotal (see instructions)		38,692,802	9,849	15,607	7,460,075	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		38,692,802	9,849	15,607	7,460,075	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D Part V Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	1,132	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,377	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,998		73.00
76.00	03610	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	5,509	2,998		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,509	2,998		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet D-1 Date/Time Prepared: 9/27/2017 1:07 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	12,037	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,037	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)	10,080	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,383	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	12,227,943	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,227,943	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)	12,227,943	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,015.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,468,374	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)	5,468,374	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,395,862	1,136	2,109.03	503	1,060,842	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,748,541	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,277,757	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)	530,013	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	435,713	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	965,726	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,312,031	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,957	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,015.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,988,038	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-1 | Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	987,179	12,227,943	0.080731	1,988,038	160,496	90.00
91.00	Nursing School cost	0	12,227,943	0.000000	1,988,038	0	91.00
92.00	Allied health cost	0	12,227,943	0.000000	1,988,038	0	92.00
93.00	All other Medical Education	0	12,227,943	0.000000	1,988,038	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet D-3 | Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		8,876,684		30.00
31.00	03100	INTENSIVE CARE UNIT		1,499,582		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.171676	4,268,020	732,717	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.694419	6,129	4,256	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.218234	1,490,445	325,266	54.00
56.00	05600	RADIOISOTOPE	0.109281	543,503	59,395	56.00
57.00	05700	CT SCAN	0.024012	2,663,825	63,964	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.117364	177,820	20,870	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.133536	554,127	73,996	59.00
60.00	06000	LABORATORY	0.509090	903,358	459,891	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.898856	213,505	191,910	63.00
65.00	06500	RESPIRATORY THERAPY	0.248712	1,667,346	414,689	65.00
66.00	06600	PHYSICAL THERAPY	0.337803	935,015	315,851	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270358	265,766	71,852	67.00
68.00	06800	SPEECH PATHOLOGY	0.412816	104,716	43,228	68.00
69.00	06900	ELECTROCARDIOLOGY	0.060195	1,693,697	101,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.634578	2,857,383	1,813,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.574084	1,920,167	1,102,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192074	5,508,850	1,058,107	73.00
76.00	03610	SLEEP LAB	0.148101	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.364057	2,114	770	90.00
91.00	09100	EMERGENCY	0.303479	2,588,888	785,673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.680260	159,623	108,585	92.00
200.00		Total (sum of lines 50-94 and 96-98)		28,524,297	7,748,541	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)		28,524,297		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part A Date/Time Prepared: 9/27/2017 1:07 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,594,954	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,032,936	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	174,289	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	2,608,668	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	101.64	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.62	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.01	31.00
32.00	Sum of lines 30 and 31	21.63	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.06	33.00
34.00	Disproportionate share adjustment (see instructions)	152,282	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part A Date/Time Prepared: 9/27/2017 1:07 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000080423	0.000079590	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	515,199	475,745	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	215,370	276,323	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	491,693		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	9,446,154		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		9,446,154	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		732,648	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,178,802	59.00
60.00	Primary payer payments		1,556	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,177,246	61.00
62.00	Deductibles billed to program beneficiaries		1,193,976	62.00
63.00	Coinsurance billed to program beneficiaries		10,626	63.00
64.00	Allowable bad debts (see instructions)		160,978	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		104,636	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		158,534	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,077,280	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-30,009	70.93
70.94	HRR adjustment amount (see instructions)		-238,084	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part A Date/Time Prepared: 9/27/2017 1:07 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,809,187	71.00
71.01	Sequestration adjustment (see instructions)		176,184	71.01
72.00	Interim payments		8,532,569	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		100,434	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		59,543	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part B Date/Time Prepared: 9/27/2017 1:07 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,507	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,460,075	2.00
3.00	PPS payments	5,284,669	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)	8,507	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	25,456	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)	25,456	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)	25,456	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	16,949	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)	8,507	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	5,284,669	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,117,881	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	4,175,295	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	4,175,295	30.00
31.00	Primary payer payments	1,058	31.00
32.00	Subtotal (line 30 minus line 31)	4,174,237	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)	83,138	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	54,040	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	81,693	36.00
37.00	Subtotal (see instructions)	4,228,277	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-5	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,228,282	40.00
40.01	Sequestration adjustment (see instructions)	84,566	40.01
41.00	Interim payments	4,207,939	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-64,223	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: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 9/27/2017 1:07 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,545,595		4,210,411	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/01/2016	13,026	12/01/2016	2,472	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-13,026		-2,472	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,532,569		4,207,939	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		100,434		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		64,223	6.02
7.00	Total Medicare program liability (see instructions)		8,633,003		4,143,716	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: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet E-1 Part II Date/Time Prepared: 9/27/2017 1:07 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,971	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	5,886	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,790	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	11,216	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	223,539,222	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	772,725	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	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)	0	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G | Date/Time Prepared: 9/27/2017 1:07 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	261,056	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	47,410,512	0	0	0	4.00
5.00	Other receivable	5,607,932	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-34,528,642	0	0	0	6.00
7.00	Inventory	1,211,917	0	0	0	7.00
8.00	Prepaid expenses	1,697,978	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,660,753	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,449,581	0	0	0	12.00
13.00	Land improvements	1,827,216	0	0	0	13.00
14.00	Accumulated depreciation	-1,790,284	0	0	0	14.00
15.00	Buildings	11,585,946	0	0	0	15.00
16.00	Accumulated depreciation	-9,403,560	0	0	0	16.00
17.00	Leasehold improvements	21,045,919	0	0	0	17.00
18.00	Accumulated depreciation	-15,901,510	0	0	0	18.00
19.00	Fixed equipment	19,432,478	0	0	0	19.00
20.00	Accumulated depreciation	-13,896,094	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	32,897,665	0	0	0	23.00
24.00	Accumulated depreciation	-26,567,577	0	0	0	24.00
25.00	Minor equipment depreciable	1,287,381	0	0	0	25.00
26.00	Accumulated depreciation	-1,186,972	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,799,335	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,579,524	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	449,532	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	4,156,171	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,605,703	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,845,980	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,370,702	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,161,149	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,607,932	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	3,493,111	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,632,894	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,269,171	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,841,482	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,110,653	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	30,743,547	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,102,433				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)	18,102,433	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,845,980	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-1 | Date/Time Prepared: 9/27/2017 1:07 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		28,015,396		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-9,912,963				2.00
3.00	Total (sum of line 1 and line 2)		18,102,433		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)		18,102,433		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)		18,102,433		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: 14-0120 | Period: From 05/01/2016 To 04/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/27/2017 1:07 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	17,643,966		17,643,966	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	17,643,966		17,643,966	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,064,010		3,064,010	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,064,010		3,064,010	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,707,976		20,707,976	17.00
18.00	Ancillary services	48,690,593	115,599,245	164,289,838	18.00
19.00	Outpatient services	5,247,597	34,516,228	39,763,825	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,334,482	1,334,482	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	PROF FEES	1,858,123	16,524,064	18,382,187	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	76,504,289	167,974,019	244,478,308	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		71,077,754		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)		71,077,754		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet G-3 Date/Time Prepared: 9/27/2017 1:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	244,478,308	1.00
2.00	Less contractual allowances and discounts on patients' accounts	185,324,568	2.00
3.00	Net patient revenues (line 1 minus line 2)	59,153,740	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	71,077,754	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-11,924,014	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	177,004	6.00
7.00	Income from investments	2,539,115	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	134,752	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	68,733	13.00
14.00	Revenue from meals sold to employees and guests	502,929	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	1,494	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	21,403	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENTS	-1,595,966	24.00
24.01	GAIN ON ASSET DISPOSAL	1,700	24.01
24.02	INVESTMENT INCOME ON SI TRUST	49,282	24.02
24.03	MISCELLANEOUS INCOME	110,605	24.03
25.00	Total other income (sum of lines 6-24)	2,011,051	25.00
26.00	Total (line 5 plus line 25)	-9,912,963	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-9,912,963	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet H | Date/Time Prepared: 9/27/2017 1:07 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		14,034	14,034	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	7,237	7,237	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	186,919	0	77,140	4,392	32,719	301,170	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	396,938	0	0	0	0	396,938	6.00
7.00	Physical Therapy	0	0	0	203,262	0	203,262	7.00
8.00	Occupational Therapy	0	0	0	82,640	0	82,640	8.00
9.00	Speech Pathology	0	0	0	2,360	0	2,360	9.00
10.00	Medical Social Services	173	0	0	0	0	173	10.00
11.00	Home Health Aide	13,434	0	0	0	0	13,434	11.00
12.00	Supplies (see instructions)	0	0	0	3,989	8,782	12,771	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	597,464	0	77,140	296,643	62,772	1,034,019	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	14,034	0	14,034			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	7,237	0	7,237			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-582	300,588	-298	300,290			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	396,938	0	396,938			6.00
7.00	Physical Therapy	0	203,262	0	203,262			7.00
8.00	Occupational Therapy	0	82,640	0	82,640			8.00
9.00	Speech Pathology	0	2,360	0	2,360			9.00
10.00	Medical Social Services	0	173	0	173			10.00
11.00	Home Health Aide	0	13,434	0	13,434			11.00
12.00	Supplies (see instructions)	-8,782	3,989	0	3,989			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-9,364	1,024,655	-298	1,024,357			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet H-1 Part I | Date/Time Prepared: 9/27/2017 1:07 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	14,034	14,034				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	7,237	0	0	7,237		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	300,290	14,034	0	7,237	0	321,561	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	396,938	0	0	0	0	396,938	6.00
7.00	Physical Therapy	203,262	0	0	0	0	203,262	7.00
8.00	Occupational Therapy	82,640	0	0	0	0	82,640	8.00
9.00	Speech Pathology	2,360	0	0	0	0	2,360	9.00
10.00	Medical Social Services	173	0	0	0	0	173	10.00
11.00	Home Health Aide	13,434	0	0	0	0	13,434	11.00
12.00	Supplies (see instructions)	3,989	0	0	0	0	3,989	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,024,357	14,034	0	7,237	0	1,024,357	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	321,561		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	181,616	578,554	6.00
7.00	Physical Therapy	93,002	296,264	7.00
8.00	Occupational Therapy	37,812	120,452	8.00
9.00	Speech Pathology	1,080	3,440	9.00
10.00	Medical Social Services	79	252	10.00
11.00	Home Health Aide	6,147	19,581	11.00
12.00	Supplies (see instructions)	1,825	5,814	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,024,357	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet H-1 Part II Date/Time Prepared: 9/27/2017 1:07 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,371				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	2,371		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	2,371	0	2,371	0	-321,561	702,796	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	396,938	6.00
7.00	Physical Therapy	0	0	0	0	0	203,262	7.00
8.00	Occupational Therapy	0	0	0	0	0	82,640	8.00
9.00	Speech Pathology	0	0	0	0	0	2,360	9.00
10.00	Medical Social Services	0	0	0	0	0	173	10.00
11.00	Home Health Aide	0	0	0	0	0	13,434	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	3,989	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,371	0	2,371	0	-321,561	702,796	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	14,034	0	7,237	0		321,561	25.00
26.00	Unit Cost Multiplier	5.919022	0.000000	3.052299	0.000000		0.457545	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0120 HHA CCN: 14-7057

Period: From 05/01/2016 To 04/30/2017

Worksheet H-2 Part I Date/Time Prepared: 9/27/2017 1:07 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	12,084	9,328	51,415	72,827	22,563	1.00
2.00	Skilled Nursing Care	578,554	0	0	109,185	687,739	213,073	2.00
3.00	Physical Therapy	296,264	0	0	0	296,264	91,787	3.00
4.00	Occupational Therapy	120,452	0	0	0	120,452	37,318	4.00
5.00	Speech Pathology	3,440	0	0	0	3,440	1,066	5.00
6.00	Medical Social Services	252	0	0	48	300	93	6.00
7.00	Home Health Aide	19,581	0	0	3,695	23,276	7,211	7.00
8.00	Supplies (see instructions)	5,814	0	0	0	5,814	1,801	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,024,357	12,084	9,328	164,343	1,210,112	374,912	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	42,925	0	19,586	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	42,925	0	19,586	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet H-2 Part I Date/Time Prepared: 9/27/2017 1:07 pm

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	185	0	0	158,086	0	158,086	1.00
2.00	Skilled Nursing Care	0	0	0	900,812	0	900,812	2.00
3.00	Physical Therapy	0	0	0	388,051	0	388,051	3.00
4.00	Occupational Therapy	0	0	0	157,770	0	157,770	4.00
5.00	Speech Pathology	0	0	0	4,506	0	4,506	5.00
6.00	Medical Social Services	0	0	0	393	0	393	6.00
7.00	Home Health Aide	0	0	0	30,487	0	30,487	7.00
8.00	Supplies (see instructions)	0	0	0	7,615	0	7,615	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	185	0	0	1,647,720	0	1,647,720	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	95,598	996,410					2.00
3.00	Physical Therapy	41,182	429,233					3.00
4.00	Occupational Therapy	16,743	174,513					4.00
5.00	Speech Pathology	478	4,984					5.00
6.00	Medical Social Services	42	435					6.00
7.00	Home Health Aide	3,235	33,722					7.00
8.00	Supplies (see instructions)	808	8,423					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	158,086	1,647,720					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.106124						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0120 HHA CCN: 14-7057

Period: From 05/01/2016 To 04/30/2017

Worksheet H-2 Part II Date/Time Prepared: 9/27/2017 1:07 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	2,371	8,341	186,919	0	72,827	2,371	1.00
2.00	Skilled Nursing Care	0	0	396,938	0	687,739	0	2.00
3.00	Physical Therapy	0	0	0	0	296,264	0	3.00
4.00	Occupational Therapy	0	0	0	0	120,452	0	4.00
5.00	Speech Pathology	0	0	0	0	3,440	0	5.00
6.00	Medical Social Services	0	0	173	0	300	0	6.00
7.00	Home Health Aide	0	0	13,434	0	23,276	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	5,814	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	2,371	8,341	597,464		1,210,112	2,371	20.00
21.00	Total cost to be allocated	12,084	9,328	164,343		374,912	42,925	21.00
22.00	Unit cost multiplier	5.096584	1.118331	0.275068		0.309816	18.104175	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (TOTAL PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,371	0	0	0	3,575	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2,371	0	0	0	3,575	20.00
21.00	Total cost to be allocated	0	19,586	0	0	0	185	21.00
22.00	Unit cost multiplier	0.000000	8.260650	0.000000	0.000000	0.000000	0.051748	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0120
HHA CCN: 14-7057

Period: From 05/01/2016 To 04/30/2017

Worksheet H-2 Part II
Date/Time Prepared: 9/27/2017 1:07 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		15.00	16.00			
1.00	Administrative and General	0	0			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0			20.00
21.00	Total cost to be allocated	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet H-3 Part I Date/Time Prepared: 9/27/2017 1:07 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	996,410		996,410	3,013	330.70	1.00
2.00	Physical Therapy	3.00	429,233	0	429,233	3,058	140.36	2.00
3.00	Occupational Therapy	4.00	174,513	0	174,513	1,239	140.85	3.00
4.00	Speech Pathology	5.00	4,984	0	4,984	19	262.32	4.00
5.00	Medical Social Services	6.00	435		435	6	72.50	5.00
6.00	Home Health Aide	7.00	33,722		33,722	815	41.38	6.00
7.00	Total (sum of lines 1-6)		1,639,297	0	1,639,297	8,150		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	0	1,708			8.00
8.01	Skilled Nursing Care		99914	0	187			8.01
9.00	Physical Therapy		37900	0	1,740			9.00
9.01	Physical Therapy		99914	0	179			9.01
10.00	Occupational Therapy		37900	0	747			10.00
10.01	Occupational Therapy		99914	0	71			10.01
11.00	Speech Pathology		37900	0	23			11.00
11.01	Speech Pathology		99914	0	0			11.01
12.00	Medical Social Services		37900	0	1			12.00
12.01	Medical Social Services		99914	0	1			12.01
13.00	Home Health Aide		37900	0	424			13.00
13.01	Home Health Aide		99914	0	60			13.01
14.00	Total (sum of lines 8-13)			0	5,141			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	8,423	0	8,423	9,781	0.861159	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,895		0	626,677		1.00
2.00	Physical Therapy	0	1,919		0	269,351		2.00
3.00	Occupational Therapy	0	818		0	115,215		3.00
4.00	Speech Pathology	0	23		0	6,033		4.00
5.00	Medical Social Services	0	2		0	145		5.00
6.00	Home Health Aide	0	484		0	20,028		6.00
7.00	Total (sum of lines 1-6)	0	5,141		0	1,037,449		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet H-3 Part I Date/Time Prepared: 9/27/2017 1:07 pm

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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	9,781	0	0	8,423	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	626,677						1.00
2.00	Physical Therapy	269,351						2.00
3.00	Occupational Therapy	115,215						3.00
4.00	Speech Pathology	6,033						4.00
5.00	Medical Social Services	145						5.00
6.00	Home Health Aide	20,028						6.00
7.00	Total (sum of lines 1-6)	1,037,449						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 14-0120 HHA CCN: 14-7057	Period: From 05/01/2016 To 04/30/2017	Worksheet H-3 Part II Date/Time Prepared: 9/27/2017 1:07 pm
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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.337803	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.270358	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.412816	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.634578	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.192074	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0120 | HHA CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 9/27/2017 1:07 pm

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	746,529	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	27,185	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,829	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	9,713	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,592	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	353	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	794,201	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	794,201	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	794,201	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	794,201	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	794,201	31.00
31.01	Sequestration adjustment (see instructions)	0	15,884	31.01
32.00	Interim payments (see instructions)	0	778,317	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0120 HHA CCN: 14-7057 | Period: From 05/01/2016 To 04/30/2017 | Worksheet H-5 Date/Time Prepared: 9/27/2017 1:07 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		778,317	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		778,317	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		778,317	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0120	Period: From 05/01/2016 To 04/30/2017	Worksheet L Parts I-III Date/Time Prepared: 9/27/2017 1:07 pm
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	688,960	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	12,823	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	31.25	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.62	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	19.01	8.00
9.00	Sum of lines 7 and 8	21.63	9.00
10.00	Allowable disproportionate share percentage (see instructions)	4.48	10.00
11.00	Disproportionate share adjustment (see instructions)	30,865	11.00
12.00	Total prospective capital payments (see instructions)	732,648	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00