

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet S Parts I-III Date/Time Prepared: 9/24/2014 9:28 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 9/24/2014 Time: 9:28 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PEKIN MEMORIAL HOSPITAL (140120) for the cost reporting period beginning 05/01/2013 and ending 04/30/2014 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	49,761	38,620	-65,054	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	115		0	9.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	49,761	38,735	-65,054	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140120		Period: From 05/01/2013 To 04/30/2014		Worksheet S-2 Part I Date/Time Prepared: 9/19/2014 2:54 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				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		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		
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF										
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA		PEKIN HOME HEALTH		147057	37900		01/01/1966	N P N		
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
17.10	Hospital-Based (CORF) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2013	04/30/2014		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	Y		22.01	
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 days	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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,232	633	7	0	91	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0		25.00	
							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

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		Beginning: 1.00	Ending: 2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N 1.00	Y/N 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	
		V 1.00	XVIII 2.00	XIX 3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through 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 Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part 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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 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	

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
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	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider 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	
<u>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.</u>						
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 non-provider 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	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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	

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	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 a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (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 a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (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
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
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	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 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 hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	655,384	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	14H076		140.00

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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			
142.00	Street: 600 SOUTH 13TH STREET	PO Box:					
143.00	City: PEKIN	State: IL		Zip Code: 61554			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
				1.00			
				2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus 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						
						0.00	
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.75	169.00	
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2012	09/30/2013	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet S-2 Part II Date/Time Prepared: 9/19/2014 2:54 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/29/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet S-2 Part II Date/Time Prepared: 9/19/2014 2:54 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
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 relieved 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.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			Y	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544		STLHEALTHCARE@BKD.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	07/29/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
9/19/2014 2:54 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Trips	Trips
	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	92	33,543	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)		92	33,543	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)		100	36,463	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	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		100				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
9/19/2014 2:54 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	7,257	1,589	13,034			1.00
2.00 HMO and other (see instructions)	1,872	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	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)	7,257	1,589	13,034			7.00
8.00 INTENSIVE CARE UNIT	676	137	1,596			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		548	884			13.00
14.00 Total (see instructions)	7,933	2,274	15,514	0.00	527.92	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	5,108	0	7,913	0.00	7.89	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	0	0	0	0.00	0.00	25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	535.81	27.00
28.00 Observation Bed Days		504	2,704			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			87			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	85	114			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part I
Date/Time Prepared:
9/19/2014 2:54 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	1,561	631	3,424	1.00
2.00 HMO and other (see instructions)				384			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1,561	631	3,424	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	0.00						25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet S-3 Part II Date/Time Prepared: 9/19/2014 2:54 pm			
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	26,212,062	0	26,212,062	1,114,480.52	23.52	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		346,453	0	346,453	6,258.28	55.36	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		2,209,422	0	2,209,422	55,186.22	40.04	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		485,295	185	485,480	18,120.83	26.79	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		1,434,184	0	1,434,184	27,774.68	51.64	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		1,788,563	0	1,788,563	45,029.16	39.72	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		6,716,672	0	6,716,672			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		120,017	0	120,017			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		69,206	0	69,206			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/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	0	265,680	265,680	9,866.37	26.93	26.00
27.00	Administrative & General	5.00	5,436,226	-265,680	5,170,546	220,868.84	23.41	27.00
28.00	Administrative & General under contract (see inst.)		729,348	0	729,348	2,634.80	276.81	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	509,002	0	509,002	22,341.93	22.78	30.00
31.00	Laundry & Linen Service	8.00	133,371	0	133,371	11,183.77	11.93	31.00
32.00	Housekeeping	9.00	770,743	0	770,743	68,967.13	11.18	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	659,401	-513,823	145,578	11,158.76	13.05	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	513,823	513,823	39,379.11	13.05	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	904,691	0	904,691	27,041.75	33.46	38.00
39.00	Central Services and Supply	14.00	90,846	0	90,846	5,945.08	15.28	39.00
40.00	Pharmacy	15.00	771,061	-771,061	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	635,579	0	635,579	35,808.96	17.75	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part II
Date/Time Prepared:
9/19/2014 2:54 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part III
Date/Time Prepared:
9/19/2014 2:54 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	24,385,535	0	24,385,535	1,055,670.82	23.10	1.00
2.00	Excluded area salaries (see instructions)	485,295	185	485,480	18,120.83	26.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,900,240	-185	23,900,055	1,037,549.99	23.04	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,222,747	0	3,222,747	72,803.84	44.27	4.00
5.00	Subtotal wage-related costs (see inst.)	6,716,672	0	6,716,672	0.00	28.10	5.00
6.00	Total (sum of lines 3 thru 5)	33,839,659	-185	33,839,474	1,110,353.83	30.48	6.00
7.00	Total overhead cost (see instructions)	10,640,268	-771,061	9,869,207	455,196.50	21.68	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 9/19/2014 2:54 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			770,301 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)			416,348 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			115,457 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			28,093 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			3,072,409 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			23,351 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			498,862 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			1,893,824 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			55,904 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			31,346 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			6,905,895 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet S-3
Part V
Date/Time Prepared:
9/19/2014 2:54 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	2,335,569	95,187	1.00
2.00	Hospital	2,068,345	95,187	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	267,224	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	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140120 Component CCN: 147057		Period: From 05/01/2013 To 04/30/2014		Worksheet S-4 Date/Time Prepared: 9/19/2014 2:54 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			TAZWELL		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	455	0	6	461 1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	439.00	21.00	87.00	547.00 2.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00 3.00	
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00 4.00	
5.00	Other Administrative Personnel			2.00	0.00	2.00 5.00	
6.00	Direct Nursing Service			3.67	0.00	3.67 6.00	
7.00	Nursing Supervisor			1.00	0.00	1.00 7.00	
8.00	Physical Therapy Service			0.00	1.70	1.70 8.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00	
10.00	Occupational Therapy Service			0.00	0.11	0.11 10.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00	
12.00	Speech Pathology Service			0.00	0.04	0.04 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			0.22	0.00	0.22 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		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,241	45	75	63	2,424 21.00	
22.00	Skilled Nursing Visit Charges	356,354	7,830	9,570	9,570	383,324 22.00	
23.00	Physical Therapy Visits	2,050	17	21	34	2,122 23.00	
24.00	Physical Therapy Visit Charges	385,510	3,230	2,280	6,460	397,480 24.00	
25.00	Occupational Therapy Visits	174	1	0	2	177 25.00	
26.00	Occupational Therapy Visit Charges	33,408	192	0	384	33,984 26.00	
27.00	Speech Pathology Visits	55	0	0	0	55 27.00	
28.00	Speech Pathology Visit Charges	11,385	0	0	0	11,385 28.00	
29.00	Medical Social Service Visits	0	0	0	0	0 29.00	
30.00	Medical Social Service Visit Charges	0	0	0	0	0 30.00	
31.00	Home Health Aide Visits	314	10	0	6	330 31.00	
32.00	Home Health Aide Visit Charges	24,569	790	0	474	25,833 32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,834	73	96	105	5,108 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)	811,226	12,042	11,850	16,888	852,006 35.00	
36.00	Total Number of Episodes (standard/non outlier)	307		27	9	343 36.00	
37.00	Total Number of Outlier Episodes		2		0	2 37.00	
38.00	Total Non-Routine Medical Supply Charges	8,094	1,978	254	101	10,427 38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet S-10 Date/Time Prepared: 9/19/2014 2:54 pm
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			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)		0.215977	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,555,769	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		3,390,847	5.00	
6.00	Medicaid charges		38,326,081	6.00	
7.00	Medicaid cost (line 1 times line 6)		8,277,552	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,330,936	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		40,926	9.00	
10.00	Stand-alone SCHIP charges		471,357	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		101,802	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		60,876	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,391,812	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	6,255,253	0	6,255,253	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,350,991	0	1,350,991	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)	1,350,991	0	1,350,991	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)		8,212,541	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		343,141	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		7,869,400	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,699,609	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,050,600	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,442,412	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 140120		Period: From 05/01/2013 To 04/30/2014		Worksheet A	
Date/Time Prepared: 9/19/2014 2:54 pm							
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		1,482,859	1,482,859	782,323	2,265,182	1.00
2.00	00200		2,503,764	2,503,764	42,231	2,545,995	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	0	6,491,843	6,491,843	475,322	6,967,165	4.00
5.00	00500	5,436,226	10,414,163	15,850,389	-1,014,381	14,836,008	5.00
7.00	00700	509,002	1,798,235	2,307,237	17,698	2,324,935	7.00
8.00	00800	133,371	103,471	236,842	0	236,842	8.00
9.00	00900	770,743	362,747	1,133,490	0	1,133,490	9.00
10.00	01000	659,401	877,562	1,536,963	-1,197,643	339,320	10.00
11.00	01100	0	0	0	1,197,643	1,197,643	11.00
13.00	01300	904,691	157,566	1,062,257	-237	1,062,020	13.00
14.00	01400	90,846	284,994	375,840	-272,928	102,912	14.00
15.00	01500	771,061	2,182,233	2,953,294	-2,668,205	285,089	15.00
16.00	01600	635,579	172,744	808,323	-1,625	806,698	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,944,381	522,448	6,466,829	-1,105,438	5,361,391	30.00
31.00	03100	1,179,494	35,947	1,215,441	17,558	1,232,999	31.00
43.00	04300	0	0	0	224,012	224,012	43.00
44.00	04400	0	-1,874	-1,874	0	-1,874	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,219,808	4,064,988	6,284,796	-3,640,988	2,643,808	50.00
52.00	05200	0	0	0	642,135	642,135	52.00
53.00	05300	350,977	596,461	947,438	-113,241	834,197	53.00
54.00	05400	1,204,966	353,385	1,558,351	76,823	1,635,174	54.00
56.00	05600	135,461	291,033	426,494	-169	426,325	56.00
57.00	05700	199,632	219,603	419,235	17,722	436,957	57.00
58.00	05800	143,075	52,576	195,651	-35,941	159,710	58.00
59.00	05900	254,432	320,159	574,591	-252,822	321,769	59.00
60.00	06000	1,089,043	1,285,010	2,374,053	-75,116	2,298,937	60.00
63.00	06300	0	519,091	519,091	38,902	557,993	63.00
65.00	06500	375,635	83,256	458,891	-48,187	410,704	65.00
66.00	06600	0	648,102	648,102	-845	647,257	66.00
67.00	06700	0	94,541	94,541	0	94,541	67.00
68.00	06800	0	175,668	175,668	1,844	177,512	68.00
69.00	06900	430,796	344,501	775,297	3,316	778,613	69.00
71.00	07100	0	0	0	3,324,397	3,324,397	71.00
72.00	07200	0	0	0	1,933,666	1,933,666	72.00
73.00	07300	0	0	0	2,706,234	2,706,234	73.00
76.00	03020	0	134,869	134,869	-35	134,834	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	118,952	16,995	135,947	-8,036	127,911	90.00
91.00	09100	2,169,195	437,153	2,606,348	-341,731	2,264,617	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	467,204	375,947	843,151	-13,656	829,495	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		710,602	710,602	-710,602	0	113.00
118.00		26,193,971	38,112,642	64,306,613	0	64,306,613	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	18,091	3,468	21,559	0	21,559	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		26,212,062	38,116,110	64,328,172	0	64,328,172	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A
Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,415	2,263,767	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-192,681	2,353,314	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,097,180	5,869,985	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,540,483	9,295,525	5.00
7.00	00700	OPERATION OF PLANT	0	2,324,935	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	236,842	8.00
9.00	00900	HOUSEKEEPING	-161	1,133,329	9.00
10.00	01000	DIETARY	0	339,320	10.00
11.00	01100	CAFETERIA	-542,952	654,691	11.00
13.00	01300	NURSING ADMINISTRATION	-108,724	953,296	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	102,912	14.00
15.00	01500	PHARMACY	-4	285,085	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-34,320	772,378	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-770	5,360,621	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,232,999	31.00
43.00	04300	NURSERY	-725	223,287	43.00
44.00	04400	SKILLED NURSING FACILITY	1,874	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,643,808	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	642,135	52.00
53.00	05300	ANESTHESIOLOGY	-741,453	92,744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,934	1,628,240	54.00
56.00	05600	RADIOISOTOPE	0	426,325	56.00
57.00	05700	CT SCAN	0	436,957	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	159,710	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	321,769	59.00
60.00	06000	LABORATORY	-67,500	2,231,437	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	557,993	63.00
65.00	06500	RESPIRATORY THERAPY	0	410,704	65.00
66.00	06600	PHYSICAL THERAPY	-3,486	643,771	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	94,541	67.00
68.00	06800	SPEECH PATHOLOGY	0	177,512	68.00
69.00	06900	ELECTROCARDIOLOGY	-299,270	479,343	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,324,397	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,933,666	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,706,234	73.00
76.00	03020	SLEEP LAB	-134,550	284	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	127,911	90.00
91.00	09100	EMERGENCY	0	2,264,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	829,495	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,770,734	55,535,879	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,559	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)	-8,770,734	55,557,438	200.00

RECLASSIFICATIONS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-6
Date/Time Prepared:
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		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - TO RECLASS CAFETERIA COSTS						
1.00	CAFETERIA	11.00	513,823	683,820	1.00	
	TOTALS		513,823	683,820		
B - TO RECLASS BLOOD SALARIES FROM LAB						
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	43,430	0	1.00	
	TOTALS		43,430	0		
C - TO RECLASS LDR EXPENSES						
1.00	NURSERY	43.00	215,244	6,425	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	617,001	18,416	2.00	
	TOTALS		832,245	24,841		
D - TO RECLASS CLINICAL ENGINEERING EXPE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	17,020	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	8,450	2.00	
3.00	INTENSIVE CARE UNIT	31.00	0	20,333	3.00	
4.00	NURSERY	43.00	0	2,161	4.00	
5.00	OPERATING ROOM	50.00	0	60,232	5.00	
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	6,196	6.00	
7.00	ANESTHESIOLOGY	53.00	0	20,402	7.00	
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	121,725	8.00	
9.00	RADIOISOTOPE	56.00	0	2,831	9.00	
10.00	CT SCAN	57.00	0	58,594	10.00	
11.00	CARDIAC CATHETERIZATION	59.00	0	45,170	11.00	
12.00	LABORATORY	60.00	0	25,670	12.00	
13.00	RESPIRATORY THERAPY	65.00	0	13,818	13.00	
14.00	PHYSICAL THERAPY	66.00	0	1,517	14.00	
15.00	SPEECH PATHOLOGY	68.00	0	1,844	15.00	
16.00	ELECTROCARDIOLOGY	69.00	0	7,770	16.00	
17.00	CLINIC	90.00	0	4,413	17.00	
18.00	EMERGENCY	91.00	0	9,706	18.00	
19.00	HOME HEALTH AGENCY	101.00	0	43	19.00	
	TOTALS		0	427,895		
E - TO RECLASS SUPPLY COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,324,397	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,933,666	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
	TOTALS		0	5,258,063		
F - TO RECLASS BILLABLE DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,949,755	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
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	
	TOTALS		0	1,949,755		

RECLASSIFICATIONS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-6

Date/Time Prepared:
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
G - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,723	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
TOTALS			0	7,723	
H - TO RECLASS HUMAN RESOURCES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	265,680	209,642	1.00
TOTALS			265,680	209,642	
I - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	710,602	1.00
TOTALS			0	710,602	
J - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	113,952	1.00
TOTALS			0	113,952	
K - TO RECLASS MRI LEASE EXPENSE					
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4,935	1.00
TOTALS			0	4,935	
L - TO RECLASS MRI BLDG UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	17,698	1.00
TOTALS			0	17,698	
M - TO RECLASS PHARMACY SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	1,499	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	4	0	2.00
3.00	NURSERY	43.00	182	0	3.00
4.00	OPERATING ROOM	50.00	1,321	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	522	0	5.00
6.00	ANESTHESIOLOGY	53.00	6,895	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	1,579	0	7.00
8.00	RADIOISOTOPE	56.00	1,626	0	8.00
9.00	CT SCAN	57.00	183	0	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	268	0	10.00
11.00	LABORATORY	60.00	38	0	11.00
12.00	RESPIRATORY THERAPY	65.00	99	0	12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	756,479	0	13.00
14.00	EMERGENCY	91.00	181	0	14.00
15.00	HOME HEALTH AGENCY	101.00	185	0	15.00
TOTALS			771,061	0	
500.00	Grand Total: Increases		2,426,239	9,408,926	500.00

RECLASSIFICATIONS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-6
Date/Time Prepared:
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		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	513,823	683,820	0		1.00
	TOTALS		513,823	683,820			
B - TO RECLASS BLOOD SALARIES FROM LAB							
1.00	LABORATORY	60.00	43,430	0	0		1.00
	TOTALS		43,430	0			
C - TO RECLASS LDR EXPENSES							
1.00	ADULTS & PEDIATRICS	30.00	832,245	24,841	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		832,245	24,841			
D - TO RECLASS CLINICAL ENGINEERING EXPE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	427,895	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
	TOTALS		0	427,895			
E - TO RECLASS SUPPLY COSTS							
1.00	NURSING ADMINISTRATION	13.00	0	237	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	270,786	0		2.00
3.00	PHARMACY	15.00	0	7,170	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	258,020	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	2,778	0		5.00
6.00	OPERATING ROOM	50.00	0	3,697,480	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	137,799	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,571	0		8.00
9.00	RADIOISOTOPE	56.00	0	4,626	0		9.00
10.00	CT SCAN	57.00	0	37,412	0		10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10,407	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	295,293	0		12.00
13.00	LABORATORY	60.00	0	57,394	0		13.00
14.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	667	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	62,103	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	2,362	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	4,440	0		17.00
18.00	SLEEP LAB	76.00	0	35	0		18.00
19.00	CLINIC	90.00	0	12,446	0		19.00
20.00	EMERGENCY	91.00	0	343,942	0		20.00
21.00	HOME HEALTH AGENCY	101.00	0	10,095	0		21.00
	TOTALS		0	5,258,063			
F - TO RECLASS BILLABLE DRUGS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,162	0		1.00
2.00	PHARMACY	15.00	0	1,889,974	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	281	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	1	0		4.00
5.00	OPERATING ROOM	50.00	0	5,061	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	2,739	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,821	0		7.00
8.00	CT SCAN	57.00	0	3,643	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	11,819	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	2,699	0		10.00
11.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	3,861	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	1	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	14	0		13.00
14.00	CLINIC	90.00	0	3	0		14.00
15.00	EMERGENCY	91.00	0	7,676	0		15.00

RECLASSIFICATIONS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-6

Date/Time Prepared:
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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	TOTALS		0	1,949,755		
G - TO RECLASS TELEPHONE EXPENSE						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,625	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,089	0	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,220	0	3.00
4.00	HOME HEALTH AGENCY	101.00	0	3,789	0	4.00
	TOTALS		0	7,723		
H - TO RECLASS HUMAN RESOURCES						
1.00	ADMINISTRATIVE & GENERAL	5.00	265,680	209,642	0	1.00
	TOTALS		265,680	209,642		
I - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	710,602	11	1.00
	TOTALS		0	710,602		
J - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113,952	0	1.00
	TOTALS		0	113,952		
K - TO RECLASS MRI LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,935	0	1.00
	TOTALS		0	4,935		
L - TO RECLASS MRI BLDG UTILITIES						
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	17,698	0	1.00
	TOTALS		0	17,698		
M - TO RECLASS PHARMACY SALARIES						
1.00	PHARMACY	15.00	771,061	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
	TOTALS		771,061	0		
500.00	Grand Total: Decreases		2,426,239	9,408,926		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-7
Part I
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,449,581	0	0	0	1.00
2.00	Land Improvements	1,827,216	0	0	0	2.00
3.00	Buildings and Fixtures	11,585,946	0	0	0	3.00
4.00	Building Improvements	18,297,682	1,491,397	0	1,491,397	4.00
5.00	Fixed Equipment	16,594,503	1,578,558	0	1,578,558	5.00
6.00	Movable Equipment	28,717,020	2,889,996	0	2,889,996	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	78,471,948	5,959,951	0	5,959,951	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	78,471,948	5,959,951	0	5,959,951	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	236,369			2.00
3.00	Buildings and Fixtures	11,585,946	0			3.00
4.00	Building Improvements	19,686,815	236,709			4.00
5.00	Fixed Equipment	18,173,061	133,113			5.00
6.00	Movable Equipment	31,448,347	4,376,696			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	84,170,966	4,982,887			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	84,170,966	4,982,887			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-7
Part II
Date/Time Prepared:
9/19/2014 2:54 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	1,441,288	1,119	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,503,764	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,945,052	1,119	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	40,452	1,482,859				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,503,764				2.00
3.00	Total (sum of lines 1-2)	40,452	3,986,623				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-7
Part III
Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	52,722,619	0	52,722,619	0.629396	71,721	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	31,448,347	404,004	31,044,343	0.370604	42,231	2.00
3.00	Total (sum of lines 1-2)	84,170,966	404,004	83,766,962	1.000000	113,952	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	71,721	1,441,288	1,119	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	42,231	2,311,083	0	2.00
3.00	Total (sum of lines 1-2)	0	0	113,952	3,752,371	1,119	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	709,187	71,721	0	40,452	2,263,767	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	42,231	0	0	2,353,314	2.00
3.00	Total (sum of lines 1-2)	709,187	113,952	0	40,452	4,617,081	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-8

Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,415	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	-585,113			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-5,076,991			0	12.00
13.00 Laundry and linen service	B	-161	HOUSEKEEPING	9.00	0	13.00
14.00 Cafeteria-employees and guests	B	-386,055	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-4	PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-34,320	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MOW & CATERING	B	-156,897	CAFETERIA	11.00	0	33.00

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-8

Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.01 WELLNESS CENTER AND AEROBICS CLASSES	B	-17,366	ELECTROCARDIOLOGY	69.00	0 33.01
33.02 PHYSICAL THERAPY OTHER INCOME	B	-3,486	PHYSICAL THERAPY	66.00	0 33.02
33.03 EDUCATION REVENUE	B	-7,565	NURSING ADMINISTRATION	13.00	0 33.03
33.04 SICKBAY REVENUE	B	-770	ADULTS & PEDIATRICS	30.00	0 33.04
33.05 RADIOLOGY TRANSCRIPT REVENUE	B	-6,934	RADIOLOGY-DIAGNOSTIC	54.00	0 33.05
33.06 NURSERY OTHER INCOME	B	-725	NURSERY	43.00	0 33.06
33.07 MISCELLANEOUS OTHER INCOME	B	-492	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 ADVERTISING SALARY EXPENSE	A	-158,533	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 ADVERTISING EXPENSE	A	-646,150	ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 ADVERTISING BENEFITS	A	-32,681	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.10
33.11 CRNA SALARIES	A	-346,453	ANESTHESIOLOGY	53.00	0 33.11
33.12 CRNA EMPLOYEE BENEFITS	A	-51,891	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.12
33.13 BOOK FAIR PROCEEDS	B	-4,876	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14 IDPA BED TAX	A	1,874	SKILLED NURSING FACILITY	44.00	0 33.14
33.15 SELF INSURANCE EXPENSE	A	-926,842	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.15
33.16 HEALTHLINK FEES	A	68,112	ADMINISTRATIVE & GENERAL	5.00	0 33.16
33.17 CRNA- OTHER	A	-395,000	ANESTHESIOLOGY	53.00	0 33.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,770,734			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140120

Period: From 05/01/2013 To 04/30/2014

Worksheet A-8-1

Date/Time Prepared: 9/19/2014 2:54 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	915,967	1,108,648	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	3,832,255	4,904,027	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	3,726,772	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	389,556	475,322	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		5,137,778	10,214,769	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.

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-8-1

Date/Time Prepared:
9/19/2014 2:54 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-192,681	9		1.00
2.00	-1,071,772	0		2.00
3.00	-3,726,772	0		3.00
4.00	-85,766	0		4.00
5.00	-5,076,991			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet A-8-2

Date/Time Prepared:
9/19/2014 2:54 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	134,550	134,550	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	101,159	101,159	0	0	0	2.00
3.00	60.00	LABORATORY	67,500	67,500	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	281,904	281,904	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			585,113	585,113	0	0	0	200.00

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

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	76.00	SLEEP LAB	0	0	0	134,550	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	101,159	2.00
3.00	60.00	LABORATORY	0	0	0	67,500	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	281,904	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	585,113	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B
Part I
Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,263,767	2,263,767			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,353,314		2,353,314		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,869,985	9,869	1,113	5,880,967	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,295,525	653,314	868,771	1,158,562	11,976,172
7.00 00700	OPERATION OF PLANT	2,324,935	332,130	37,494	117,659	2,812,218
8.00 00800	LAUNDRY & LINEN SERVICE	236,842	25,019	22,364	30,830	315,055
9.00 00900	HOUSEKEEPING	1,133,329	1,987	480	178,163	1,313,959
10.00 01000	DIETARY	339,320	47,630	4,623	33,651	425,224
11.00 01100	CAFETERIA	654,691	13,323	16,314	118,774	803,102
13.00 01300	NURSING ADMINISTRATION	953,296	32,407	49,589	209,126	1,244,418
14.00 01400	CENTRAL SERVICES & SUPPLY	102,912	34,674	65,062	21,000	223,648
15.00 01500	PHARMACY	285,085	11,469	13,015	0	309,569
16.00 01600	MEDICAL RECORDS & LIBRARY	772,378	28,659	17,830	146,919	965,786
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,360,621	276,139	105,044	1,182,059	6,923,863
31.00 03100	INTENSIVE CARE UNIT	1,232,999	26,579	22,715	272,649	1,554,942
43.00 04300	NURSERY	223,287	6,908	6,910	49,797	286,902
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,643,808	136,582	292,561	513,430	3,586,381
52.00 05200	DELIVERY ROOM & LABOR ROOM	642,135	22,405	19,807	142,745	827,092
53.00 05300	ANESTHESIOLOGY	92,744	2,327	53,230	2,640	150,941
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,628,240	104,369	476,241	278,901	2,487,751
56.00 05600	RADIOISOTOPE	426,325	5,835	3,076	31,689	466,925
57.00 05700	CT SCAN	436,957	5,134	4,366	46,189	492,646
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	159,710	13,550	51,705	33,135	258,100
59.00 05900	CARDIAC CATHETERIZATION	321,769	5,101	26,159	58,814	411,843
60.00 06000	LABORATORY	2,231,437	40,135	53,932	241,710	2,567,214
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	557,993	0	1,306	10,039	569,338
65.00 06500	RESPIRATORY THERAPY	410,704	10,175	23,955	86,854	531,688
66.00 06600	PHYSICAL THERAPY	643,771	26,339	2,266	0	672,376
67.00 06700	OCCUPATIONAL THERAPY	94,541	3,201	58	0	97,800
68.00 06800	SPEECH PATHOLOGY	177,512	12,323	0	0	189,835
69.00 06900	ELECTROCARDIOLOGY	479,343	35,514	74,098	99,582	688,537
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,324,397	0	0	0	3,324,397
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,933,666	0	0	0	1,933,666
73.00 07300	DRUGS CHARGED TO PATIENTS	2,706,234	0	0	174,865	2,881,099
76.00 03020	SLEEP LAB	284	4,934	0	0	5,218
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	127,911	13,476	2,014	27,497	170,898
91.00 09100	EMERGENCY	2,264,617	98,107	27,972	501,466	2,892,162
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	829,495	0	9,128	108,040	946,663
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,535,879	2,039,614	2,353,198	5,876,785	55,307,428
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,559	26,592	116	4,182	52,449
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	121,939	0	0	121,939
194.00 07950	VACANT SPACE	0	38,488	0	0	38,488
194.01 07951	LEASED SPACE	0	33,827	0	0	33,827
194.02 07952	FOUNDATION	0	3,307	0	0	3,307
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	55,557,438	2,263,767	2,353,314	5,880,967	55,557,438

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B
Part I
Date/Time Prepared:
9/19/2014 2:54 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	11,976,172				5.00
7.00	00700	OPERATION OF PLANT	772,800	3,585,018			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	86,577	70,710	472,342		8.00
9.00	00900	HOUSEKEEPING	361,077	5,616	8,186	1,688,838	9.00
10.00	01000	DIETARY	116,852	134,616	628	64,795	742,115
11.00	01100	CAFETERIA	220,693	37,654	0	18,124	0
13.00	01300	NURSING ADMINISTRATION	341,967	91,591	0	44,086	0
14.00	01400	CENTRAL SERVICES & SUPPLY	61,459	97,999	2,464	47,170	0
15.00	01500	PHARMACY	85,070	32,415	0	15,602	0
16.00	01600	MEDICAL RECORDS & LIBRARY	265,399	81,000	0	38,988	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,902,679	780,447	174,723	375,651	661,779
31.00	03100	INTENSIVE CARE UNIT	427,300	75,120	70,794	36,157	80,336
43.00	04300	NURSERY	78,841	19,524	8,085	9,398	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	985,541	386,021	64,922	185,803	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	227,286	63,322	69,694	30,479	0
53.00	05300	ANESTHESIOLOGY	41,479	6,577	0	3,166	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	683,636	294,976	40,375	141,981	0
56.00	05600	RADIOISOTOPE	128,311	16,490	0	7,937	0
57.00	05700	CT SCAN	135,380	14,511	0	6,985	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	70,926	38,295	2,985	18,432	0
59.00	05900	CARDIAC CATHETERIZATION	113,175	14,417	0	6,939	0
60.00	06000	LABORATORY	705,473	113,433	144	54,599	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	156,455	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	146,108	28,759	0	13,842	0
66.00	06600	PHYSICAL THERAPY	184,770	74,441	6,879	35,831	0
67.00	06700	OCCUPATIONAL THERAPY	26,876	9,046	0	4,354	0
68.00	06800	SPEECH PATHOLOGY	52,167	34,827	0	16,763	0
69.00	06900	ELECTROCARDIOLOGY	189,211	100,373	937	48,313	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	913,548	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	531,373	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	791,729	0	0	0	0
76.00	03020	SLEEP LAB	1,434	13,946	606	6,713	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	46,963	38,088	0	18,333	0
91.00	09100	EMERGENCY	794,769	277,280	6,542	133,463	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	260,144	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,907,468	2,951,494	457,964	1,383,904	742,115
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,413	75,157	0	36,176	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,509	344,635	13,976	165,883	0
194.00	07950	VACANT SPACE	10,577	108,779	0	52,358	0
194.01	07951	LEASED SPACE	9,296	95,605	402	46,018	0
194.02	07952	FOUNDATION	909	9,348	0	4,499	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	11,976,172	3,585,018	472,342	1,688,838	742,115

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet B Part I Date/Time Prepared: 9/19/2014 2:54 pm
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,079,573					11.00
13.00	01300	40,867	1,762,929				13.00
14.00	01400	8,991	0	441,731			14.00
15.00	01500	0	0	605	443,261		15.00
16.00	01600	54,133	0	819	0	1,406,125	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	322,028	1,524,436	5,457	862	835,611	30.00
31.00	03100	62,495	153,482	328	2	40,609	31.00
43.00	04300	11,883	85,011	120	105	61,180	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	128,384	0	7,662	759	300,528	50.00
52.00	05200	34,077	0	343	300	0	52.00
53.00	05300	10,468	0	871	3,964	0	53.00
54.00	05400	81,639	0	1,452	908	0	54.00
56.00	05600	6,067	0	15	935	0	56.00
57.00	05700	11,065	0	55	105	0	57.00
58.00	05800	10,060	0	155	154	0	58.00
59.00	05900	12,134	0	175	0	0	59.00
60.00	06000	71,611	0	2,191	22	0	60.00
63.00	06300	2,986	0	7	0	0	63.00
65.00	06500	26,029	0	310	57	114,955	65.00
66.00	06600	0	0	353	0	0	66.00
67.00	06700	0	0	6	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	26,155	0	416	0	0	69.00
71.00	07100	0	0	261,752	0	0	71.00
72.00	07200	0	0	152,251	0	0	72.00
73.00	07300	31,342	0	0	434,878	0	73.00
76.00	03020	0	0	22	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8,582	0	235	0	0	90.00
91.00	09100	115,999	0	5,560	104	53,242	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	370	106	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,076,995	1,762,929	441,530	443,261	1,406,125	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,578	0	201	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,079,573	1,762,929	441,731	443,261	1,406,125	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B
Part I
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	13,507,536	0	13,507,536	30.00
31.00	03100	2,501,565	0	2,501,565	31.00
43.00	04300	561,049	0	561,049	43.00
44.00	04400	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	5,646,001	0	5,646,001	50.00
52.00	05200	1,252,593	0	1,252,593	52.00
53.00	05300	217,466	0	217,466	53.00
54.00	05400	3,732,718	0	3,732,718	54.00
56.00	05600	626,680	0	626,680	56.00
57.00	05700	660,747	0	660,747	57.00
58.00	05800	399,107	0	399,107	58.00
59.00	05900	558,683	0	558,683	59.00
60.00	06000	3,514,687	0	3,514,687	60.00
63.00	06300	728,786	0	728,786	63.00
65.00	06500	861,748	0	861,748	65.00
66.00	06600	974,650	0	974,650	66.00
67.00	06700	138,082	0	138,082	67.00
68.00	06800	293,592	0	293,592	68.00
69.00	06900	1,053,942	0	1,053,942	69.00
71.00	07100	4,499,697	0	4,499,697	71.00
72.00	07200	2,617,290	0	2,617,290	72.00
73.00	07300	4,139,048	0	4,139,048	73.00
76.00	03020	27,939	0	27,939	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	283,099	0	283,099	90.00
91.00	09100	4,279,121	0	4,279,121	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	0	0	0	99.00
99.10	09910	0	0	0	99.10
100.00	10000	0	0	0	100.00
101.00	10100	1,207,283	0	1,207,283	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		54,283,109	0	54,283,109	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	180,974	0	180,974	190.00
192.00	19200	679,942	0	679,942	192.00
194.00	07950	210,202	0	210,202	194.00
194.01	07951	185,148	0	185,148	194.01
194.02	07952	18,063	0	18,063	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		55,557,438	0	55,557,438	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B
Part II
Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,869	1,113	10,982	10,982 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	24,503	653,314	868,771	1,546,588	2,165 5.00
7.00 00700	OPERATION OF PLANT	7,050	332,130	37,494	376,674	220 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	25,019	22,364	47,383	58 8.00
9.00 00900	HOUSEKEEPING	0	1,987	480	2,467	333 9.00
10.00 01000	DIETARY	0	47,630	4,623	52,253	63 10.00
11.00 01100	CAFETERIA	0	13,323	16,314	29,637	222 11.00
13.00 01300	NURSING ADMINISTRATION	0	32,407	49,589	81,996	391 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	12,815	34,674	65,062	112,551	39 14.00
15.00 01500	PHARMACY	176,263	11,469	13,015	200,747	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	28,659	17,830	46,489	275 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	24,995	276,139	105,044	406,178	2,199 30.00
31.00 03100	INTENSIVE CARE UNIT	11,355	26,579	22,715	60,649	510 31.00
43.00 04300	NURSERY	0	6,908	6,910	13,818	93 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,806	136,582	292,561	436,949	960 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	22,405	19,807	42,212	267 52.00
53.00 05300	ANESTHESIOLOGY	2,509	2,327	53,230	58,066	5 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,348	104,369	476,241	586,958	521 54.00
56.00 05600	RADIOISOTOPE	0	5,835	3,076	8,911	59 56.00
57.00 05700	CT SCAN	0	5,134	4,366	9,500	86 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,935	13,550	51,705	70,190	62 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	5,101	26,159	31,260	110 59.00
60.00 06000	LABORATORY	0	40,135	53,932	94,067	452 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,306	1,306	19 63.00
65.00 06500	RESPIRATORY THERAPY	8,363	10,175	23,955	42,493	162 65.00
66.00 06600	PHYSICAL THERAPY	0	26,339	2,266	28,605	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	3,201	58	3,259	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	12,323	0	12,323	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	35,514	74,098	109,612	186 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	327 73.00
76.00 03020	SLEEP LAB	0	4,934	0	4,934	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	13,476	2,014	15,490	51 90.00
91.00 09100	EMERGENCY	0	98,107	27,972	126,079	937 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	0 99.00
99.10 09910	CORF	0	0	0	0	0 99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
101.00 10100	HOME HEALTH AGENCY	14,000	0	9,128	23,128	202 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	300,942	2,039,614	2,353,198	4,693,754	10,974 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,592	116	26,708	8 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	121,939	0	121,939	0 192.00
194.00 07950	VACANT SPACE	0	38,488	0	38,488	0 194.00
194.01 07951	LEASED SPACE	0	33,827	0	33,827	0 194.01
194.02 07952	FOUNDATION	0	3,307	0	3,307	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)	300,942	2,263,767	2,353,314	4,918,023	10,982 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B
Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,548,753				5.00
7.00	00700	OPERATION OF PLANT	99,938	476,832			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,196	9,405	68,042		8.00
9.00	00900	HOUSEKEEPING	46,694	747	1,179	51,420	9.00
10.00	01000	DIETARY	15,111	17,905	91	1,973	87,396
11.00	01100	CAFETERIA	28,540	5,008	0	552	0
13.00	01300	NURSING ADMINISTRATION	44,223	12,182	0	1,342	0
14.00	01400	CENTRAL SERVICES & SUPPLY	7,948	13,034	355	1,436	0
15.00	01500	PHARMACY	11,001	4,311	0	475	0
16.00	01600	MEDICAL RECORDS & LIBRARY	34,321	10,774	0	1,187	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	246,057	103,809	25,169	11,439	77,935
31.00	03100	INTENSIVE CARE UNIT	55,258	9,991	10,198	1,101	9,461
43.00	04300	NURSERY	10,196	2,597	1,165	286	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	127,449	51,343	9,352	5,657	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,392	8,422	10,040	928	0
53.00	05300	ANESTHESIOLOGY	5,364	875	0	96	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,407	39,234	5,816	4,323	0
56.00	05600	RADIOISOTOPE	16,593	2,193	0	242	0
57.00	05700	CT SCAN	17,507	1,930	0	213	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,172	5,093	430	561	0
59.00	05900	CARDIAC CATHETERIZATION	14,636	1,918	0	211	0
60.00	06000	LABORATORY	91,231	15,087	21	1,662	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20,233	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	18,895	3,825	0	421	0
66.00	06600	PHYSICAL THERAPY	23,894	9,901	991	1,091	0
67.00	06700	OCCUPATIONAL THERAPY	3,476	1,203	0	133	0
68.00	06800	SPEECH PATHOLOGY	6,746	4,632	0	510	0
69.00	06900	ELECTROCARDIOLOGY	24,469	13,350	135	1,471	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,139	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	68,717	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	102,386	0	0	0	0
76.00	03020	SLEEP LAB	185	1,855	87	204	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,073	5,066	0	558	0
91.00	09100	EMERGENCY	102,779	36,880	942	4,064	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	33,642	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,539,868	392,570	65,971	42,136	87,396
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,864	9,996	0	1,101	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,333	45,839	2,013	5,051	0
194.00	07950	VACANT SPACE	1,368	14,468	0	1,594	0
194.01	07951	LEASED SPACE	1,202	12,716	58	1,401	0
194.02	07952	FOUNDATION	118	1,243	0	137	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,548,753	476,832	68,042	51,420	87,396

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B
Part II
Date/Time Prepared:
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	63,959					11.00
13.00	01300	2,421	142,555				13.00
14.00	01400	533	0	135,896			14.00
15.00	01500	0	0	186	216,720		15.00
16.00	01600	3,207	0	252	0	96,505	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,078	123,270	1,679	421	57,349	30.00
31.00	03100	3,702	12,411	101	1	2,787	31.00
43.00	04300	704	6,874	37	51	4,199	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,606	0	2,357	371	20,626	50.00
52.00	05200	2,019	0	106	147	0	52.00
53.00	05300	620	0	268	1,938	0	53.00
54.00	05400	4,837	0	447	444	0	54.00
56.00	05600	359	0	5	457	0	56.00
57.00	05700	656	0	17	51	0	57.00
58.00	05800	596	0	48	75	0	58.00
59.00	05900	719	0	54	0	0	59.00
60.00	06000	4,243	0	674	11	0	60.00
63.00	06300	177	0	2	0	0	63.00
65.00	06500	1,542	0	95	28	7,890	65.00
66.00	06600	0	0	109	0	0	66.00
67.00	06700	0	0	2	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,550	0	128	0	0	69.00
71.00	07100	0	0	80,525	0	0	71.00
72.00	07200	0	0	46,839	0	0	72.00
73.00	07300	1,857	0	0	212,622	0	73.00
76.00	03020	0	0	7	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	508	0	72	0	0	90.00
91.00	09100	6,872	0	1,710	51	3,654	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	114	52	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		63,806	142,555	135,834	216,720	96,505	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	153	0	62	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		63,959	142,555	135,896	216,720	96,505	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B
Part II
Date/Time Prepared:
9/19/2014 2:54 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				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	1,074,583	0	1,074,583	30.00
31.00	03100	166,170	0	166,170	31.00
43.00	04300	40,020	0	40,020	43.00
44.00	04400	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	662,670	0	662,670	50.00
52.00	05200	93,533	0	93,533	52.00
53.00	05300	67,232	0	67,232	53.00
54.00	05400	730,987	0	730,987	54.00
56.00	05600	28,819	0	28,819	56.00
57.00	05700	29,960	0	29,960	57.00
58.00	05800	86,227	0	86,227	58.00
59.00	05900	48,908	0	48,908	59.00
60.00	06000	207,448	0	207,448	60.00
63.00	06300	21,737	0	21,737	63.00
65.00	06500	75,351	0	75,351	65.00
66.00	06600	64,591	0	64,591	66.00
67.00	06700	8,073	0	8,073	67.00
68.00	06800	24,211	0	24,211	68.00
69.00	06900	150,901	0	150,901	69.00
71.00	07100	198,664	0	198,664	71.00
72.00	07200	115,556	0	115,556	72.00
73.00	07300	317,192	0	317,192	73.00
76.00	03020	7,272	0	7,272	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	27,818	0	27,818	90.00
91.00	09100	283,968	0	283,968	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900	0	0	0	99.00
99.10	09910	0	0	0	99.10
100.00	10000	0	0	0	100.00
101.00	10100	57,138	0	57,138	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		4,589,029	0	4,589,029	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	39,892	0	39,892	190.00
192.00	19200	179,175	0	179,175	192.00
194.00	07950	55,918	0	55,918	194.00
194.01	07951	49,204	0	49,204	194.01
194.02	07952	4,805	0	4,805	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		4,918,023	0	4,918,023	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B-1

Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	339,493					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,312,202				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,480	1,094	25,441,396			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	97,976	853,592	5,012,013	-11,976,172	43,581,266	5.00
7.00 00700	OPERATION OF PLANT	49,809	36,839	509,002	0	2,812,218	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	3,752	21,973	133,371	0	315,055	8.00
9.00 00900	HOUSEKEEPING	298	472	770,743	0	1,313,959	9.00
10.00 01000	DIETARY	7,143	4,542	145,578	0	425,224	10.00
11.00 01100	CAFETERIA	1,998	16,029	513,823	0	803,102	11.00
13.00 01300	NURSING ADMINISTRATION	4,860	48,723	904,691	0	1,244,418	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	5,200	63,925	90,846	0	223,648	14.00
15.00 01500	PHARMACY	1,720	12,788	0	0	309,569	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,298	17,519	635,579	0	965,786	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	41,412	103,209	5,113,635	0	6,923,863	30.00
31.00 03100	INTENSIVE CARE UNIT	3,986	22,318	1,179,498	0	1,554,942	31.00
43.00 04300	NURSERY	1,036	6,789	215,426	0	286,902	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	20,483	287,450	2,221,129	0	3,586,381	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,360	19,461	617,523	0	827,092	52.00
53.00 05300	ANESTHESIOLOGY	349	52,300	11,419	0	150,941	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,652	467,921	1,206,545	0	2,487,751	54.00
56.00 05600	RADIOISOTOPE	875	3,022	137,087	0	466,925	56.00
57.00 05700	CT SCAN	770	4,290	199,815	0	492,646	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	50,802	143,343	0	258,100	58.00
59.00 05900	CARDIAC CATHETERIZATION	765	25,702	254,432	0	411,843	59.00
60.00 06000	LABORATORY	6,019	52,990	1,045,651	0	2,567,214	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	1,283	43,430	0	569,338	63.00
65.00 06500	RESPIRATORY THERAPY	1,526	23,537	375,734	0	531,688	65.00
66.00 06600	PHYSICAL THERAPY	3,950	2,226	0	0	672,376	66.00
67.00 06700	OCCUPATIONAL THERAPY	480	57	0	0	97,800	67.00
68.00 06800	SPEECH PATHOLOGY	1,848	0	0	0	189,835	68.00
69.00 06900	ELECTROCARDIOLOGY	5,326	72,804	430,796	0	688,537	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,324,397	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,933,666	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	756,479	0	2,881,099	73.00
76.00 03020	SLEEP LAB	740	0	0	0	5,218	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	2,021	1,979	118,952	0	170,898	90.00
91.00 09100	EMERGENCY	14,713	27,483	2,169,376	0	2,892,162	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00 09900	CMHC	0	0	0	0	0	99.00
99.10 09910	CORF	0	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	8,969	467,389	0	946,663	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	305,877	2,312,088	25,423,305	-11,976,172	43,331,256	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	114	18,091	0	52,449	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	18,287	0	0	0	121,939	192.00
194.00 07950	VACANT SPACE	5,772	0	0	0	38,488	194.00
194.01 07951	LEASED SPACE	5,073	0	0	0	33,827	194.01
194.02 07952	FOUNDATION	496	0	0	0	3,307	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,263,767	2,353,314	5,880,967		11,976,172	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.668082	1.017780	0.231157		0.274801	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			10,982		1,548,753	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000432		0.035537	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B-1

Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	190,228				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	3,752	732,226			8.00	
9.00	00900	HOUSEKEEPING	298	12,690	186,178		9.00	
10.00	01000	DIETARY	7,143	974	7,143	58,225	10.00	
11.00	01100	CAFETERIA	1,998	0	1,998	0	34,342	11.00
13.00	01300	NURSING ADMINISTRATION	4,860	0	4,860	0	1,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,200	3,820	5,200	0	286	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	1,722	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,412	270,852	41,412	51,922	10,244	30.00
31.00	03100	INTENSIVE CARE UNIT	3,986	109,745	3,986	6,303	1,988	31.00
43.00	04300	NURSERY	1,036	12,533	1,036	0	378	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,483	100,643	20,483	0	4,084	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,360	108,040	3,360	0	1,084	52.00
53.00	05300	ANESTHESIOLOGY	349	0	349	0	333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,652	62,590	15,652	0	2,597	54.00
56.00	05600	RADIOISOTOPE	875	0	875	0	193	56.00
57.00	05700	CT SCAN	770	0	770	0	352	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,032	4,628	2,032	0	320	58.00
59.00	05900	CARDIAC CATHETERIZATION	765	0	765	0	386	59.00
60.00	06000	LABORATORY	6,019	224	6,019	0	2,278	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	95	63.00
65.00	06500	RESPIRATORY THERAPY	1,526	0	1,526	0	828	65.00
66.00	06600	PHYSICAL THERAPY	3,950	10,664	3,950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	480	0	480	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	1,848	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,326	1,452	5,326	0	832	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	997	73.00
76.00	03020	SLEEP LAB	740	940	740	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,021	0	2,021	0	273	90.00
91.00	09100	EMERGENCY	14,713	10,142	14,713	0	3,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	156,612	709,937	152,562	58,225	34,260	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,988	0	3,988	0	82	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,287	21,666	18,287	0	0	192.00
194.00	07950	VACANT SPACE	5,772	0	5,772	0	0	194.00
194.01	07951	LEASED SPACE	5,073	623	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)	3,585,018	472,342	1,688,838	742,115	1,079,573	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.845901	0.645077	9.071093	12.745642	31.435939	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	476,832	68,042	51,420	87,396	63,959	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.506634	0.092925	0.276187	1.501005	1.862413	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet B-1
Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description		NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	18,332				13.00
14.00	01400	0	5,610,202			14.00
15.00	01500	0	7,683	1,987,338		15.00
16.00	01600	0	10,400	0	29,051	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	15,852	69,304	3,864	17,264	30.00
31.00	03100	1,596	4,163	10	839	31.00
43.00	04300	884	1,522	469	1,264	43.00
44.00	04400	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	97,307	3,405	6,209	50.00
52.00	05200	0	4,361	1,345	0	52.00
53.00	05300	0	11,059	17,772	0	53.00
54.00	05400	0	18,446	4,070	0	54.00
56.00	05600	0	186	4,190	0	56.00
57.00	05700	0	694	471	0	57.00
58.00	05800	0	1,966	692	0	58.00
59.00	05900	0	2,221	0	0	59.00
60.00	06000	0	27,833	98	0	60.00
63.00	06300	0	94	0	0	63.00
65.00	06500	0	3,936	254	2,375	65.00
66.00	06600	0	4,485	0	0	66.00
67.00	06700	0	72	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	5,284	0	0	69.00
71.00	07100	0	3,324,397	0	0	71.00
72.00	07200	0	1,933,666	0	0	72.00
73.00	07300	0	0	1,949,755	0	73.00
76.00	03020	0	284	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	2,980	0	0	90.00
91.00	09100	0	70,611	467	1,100	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	0	0	0	0	99.00
99.10	09910	0	0	0	0	99.10
100.00	10000	0	0	0	0	100.00
101.00	10100	0	4,699	476	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		18,332	5,607,653	1,987,338	29,051	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	2,549	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		1,762,929	441,731	443,261	1,406,125	202.00
203.00		96.166758	0.078737	0.223043	48.401948	203.00
204.00		142,555	135,896	216,720	96,505	204.00
205.00		7.776293	0.024223	0.109050	3.321917	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet C
Part I
Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		PPS
				Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	13,507,536		13,507,536	0	13,507,536 30.00
31.00	03100 INTENSIVE CARE UNIT	2,501,565		2,501,565	0	2,501,565 31.00
43.00	04300 NURSERY	561,049		561,049	0	561,049 43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,646,001		5,646,001	0	5,646,001 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,252,593		1,252,593	0	1,252,593 52.00
53.00	05300 ANESTHESIOLOGY	217,466		217,466	0	217,466 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,732,718		3,732,718	0	3,732,718 54.00
56.00	05600 RADIOISOTOPE	626,680		626,680	0	626,680 56.00
57.00	05700 CT SCAN	660,747		660,747	0	660,747 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	399,107		399,107	0	399,107 58.00
59.00	05900 CARDIAC CATHETERIZATION	558,683		558,683	0	558,683 59.00
60.00	06000 LABORATORY	3,514,687		3,514,687	0	3,514,687 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	728,786		728,786	0	728,786 63.00
65.00	06500 RESPIRATORY THERAPY	861,748	0	861,748	0	861,748 65.00
66.00	06600 PHYSICAL THERAPY	974,650	0	974,650	0	974,650 66.00
67.00	06700 OCCUPATIONAL THERAPY	138,082	0	138,082	0	138,082 67.00
68.00	06800 SPEECH PATHOLOGY	293,592	0	293,592	0	293,592 68.00
69.00	06900 ELECTROCARDIOLOGY	1,053,942		1,053,942	0	1,053,942 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,499,697		4,499,697	0	4,499,697 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,617,290		2,617,290	0	2,617,290 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,139,048		4,139,048	0	4,139,048 73.00
76.00	03020 SLEEP LAB	27,939		27,939	0	27,939 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	283,099		283,099	0	283,099 90.00
91.00	09100 EMERGENCY	4,279,121		4,279,121	0	4,279,121 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,320,789		2,320,789	0	2,320,789 92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0		0	0	0 99.00
99.10	09910 CORF	0		0	0	0 99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0 100.00
101.00	10100 HOME HEALTH AGENCY	1,207,283		1,207,283	0	1,207,283 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	56,603,898	0	56,603,898	0	56,603,898 200.00
201.00	Less Observation Beds	2,320,789		2,320,789	0	2,320,789 201.00
202.00	Total (see instructions)	54,283,109	0	54,283,109	0	54,283,109 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet C Part I Date/Time Prepared: 9/19/2014 2:54 pm
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		Title XVIIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,193,619		21,193,619		30.00
31.00	03100	INTENSIVE CARE UNIT	3,889,903		3,889,903		31.00
43.00	04300	NURSERY	814,104		814,104		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,601,831	32,383,449	42,985,280	0.131347	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,091,479	241,755	2,333,234	0.536848	52.00
53.00	05300	ANESTHESIOLOGY	256,688	401,891	658,579	0.330205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,530,595	14,494,252	18,024,847	0.207087	54.00
56.00	05600	RADIOISOTOPE	1,161,734	5,080,018	6,241,752	0.100401	56.00
57.00	05700	CT SCAN	4,448,607	17,986,755	22,435,362	0.029451	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	707,675	5,709,209	6,416,884	0.062196	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,091,112	1,369,085	2,460,197	0.227089	59.00
60.00	06000	LABORATORY	10,049,200	17,910,679	27,959,879	0.125705	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	830,247	331,073	1,161,320	0.627550	63.00
65.00	06500	RESPIRATORY THERAPY	3,750,037	350,956	4,100,993	0.210132	65.00
66.00	06600	PHYSICAL THERAPY	1,462,342	1,688,399	3,150,741	0.309340	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,397	269,121	444,518	0.310633	67.00
68.00	06800	SPEECH PATHOLOGY	172,749	172,275	345,024	0.850932	68.00
69.00	06900	ELECTROCARDIOLOGY	3,147,849	6,979,811	10,127,660	0.104066	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,887,480	3,361,092	11,248,572	0.400024	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,486,854	1,665,190	6,152,044	0.425434	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,655,759	8,761,263	22,417,022	0.184639	73.00
76.00	03020	SLEEP LAB	5,466	1,595,812	1,601,278	0.017448	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	522	1,187,613	1,188,135	0.238272	90.00
91.00	09100	EMERGENCY	4,542,923	24,164,381	28,707,304	0.149060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	404,365	3,264,522	3,668,887	0.632559	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	1,610,531	1,610,531		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	100,358,537	150,979,132	251,337,669		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	100,358,537	150,979,132	251,337,669		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet C Part I Date/Time Prepared: 9/19/2014 2:54 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.131347		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.536848		52.00
53.00	05300 ANESTHESIOLOGY	0.330205		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207087		54.00
56.00	05600 RADIOISOTOPE	0.100401		56.00
57.00	05700 CT SCAN	0.029451		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.062196		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.227089		59.00
60.00	06000 LABORATORY	0.125705		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.627550		63.00
65.00	06500 RESPIRATORY THERAPY	0.210132		65.00
66.00	06600 PHYSICAL THERAPY	0.309340		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.310633		67.00
68.00	06800 SPEECH PATHOLOGY	0.850932		68.00
69.00	06900 ELECTROCARDIOLOGY	0.104066		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.400024		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.425434		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.184639		73.00
76.00	03020 SLEEP LAB	0.017448		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.238272		90.00
91.00	09100 EMERGENCY	0.149060		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.632559		92.00
OTHER REIMBURSABLE COST CENTERS				
99.00	09900 CMHC			99.00
99.10	09910 CORF			99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140120		Period: From 05/01/2013 To 04/30/2014		Worksheet D Part I Date/Time Prepared: 9/19/2014 2:54 pm	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,074,583	0	1,074,583	15,738	68.28	30.00
31.00	INTENSIVE CARE UNIT	166,170		166,170	1,596	104.12	31.00
43.00	NURSERY	40,020		40,020	884	45.27	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	1,280,773		1,280,773	18,218		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	7,257	495,508				
31.00	INTENSIVE CARE UNIT	676	70,385				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	7,933	565,893				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part II Date/Time Prepared: 9/19/2014 2:54 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	662,670	42,985,280	0.015416	4,980,159	76,774	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	93,533	2,333,234	0.040087	12,891	517	52.00
53.00	05300 ANESTHESIOLOGY	67,232	658,579	0.102086	94,387	9,636	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	730,987	18,024,847	0.040554	2,044,520	82,913	54.00
56.00	05600 RADIOISOTOPE	28,819	6,241,752	0.004617	751,882	3,471	56.00
57.00	05700 CT SCAN	29,960	22,435,362	0.001335	2,336,032	3,119	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	86,227	6,416,884	0.013438	395,398	5,313	58.00
59.00	05900 CARDIAC CATHETERIZATION	48,908	2,460,197	0.019880	728,649	14,486	59.00
60.00	06000 LABORATORY	207,448	27,959,879	0.007419	5,462,590	40,527	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	21,737	1,161,320	0.018717	530,123	9,922	63.00
65.00	06500 RESPIRATORY THERAPY	75,351	4,100,993	0.018374	2,300,758	42,274	65.00
66.00	06600 PHYSICAL THERAPY	64,591	3,150,741	0.020500	965,400	19,791	66.00
67.00	06700 OCCUPATIONAL THERAPY	8,073	444,518	0.018161	112,805	2,049	67.00
68.00	06800 SPEECH PATHOLOGY	24,211	345,024	0.070172	111,595	7,831	68.00
69.00	06900 ELECTROCARDIOLOGY	150,901	10,127,660	0.014900	2,043,375	30,446	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	198,664	11,248,572	0.017661	4,554,137	80,431	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	115,556	6,152,044	0.018783	2,478,710	46,558	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	317,192	22,417,022	0.014150	7,356,246	104,091	73.00
76.00	03020 SLEEP LAB	7,272	1,601,278	0.004541	5,466	25	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	27,818	1,188,135	0.023413	522	12	90.00
91.00	09100 EMERGENCY	283,968	28,707,304	0.009892	2,557,065	25,294	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	184,628	3,668,887	0.050323	265,185	13,345	92.00
200.00	Total (lines 50-199)	3,435,746	223,829,512		40,087,895	618,825	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140120		Period: From 05/01/2013 To 04/30/2014		Worksheet D Part III Date/Time Prepared: 9/19/2014 2:54 pm	
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	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,738	0.00	7,257	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,596	0.00	676	0		31.00
43.00	04300	NURSERY	884	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	18,218		7,933	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet D
Part IV
Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part IV Date/Time Prepared: 9/19/2014 2:54 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	42,985,280	0.000000	0.000000	4,980,159	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,333,234	0.000000	0.000000	12,891	52.00
53.00	05300 ANESTHESIOLOGY	0	658,579	0.000000	0.000000	94,387	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	18,024,847	0.000000	0.000000	2,044,520	54.00
56.00	05600 RADIOISOTOPE	0	6,241,752	0.000000	0.000000	751,882	56.00
57.00	05700 CT SCAN	0	22,435,362	0.000000	0.000000	2,336,032	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	6,416,884	0.000000	0.000000	395,398	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,460,197	0.000000	0.000000	728,649	59.00
60.00	06000 LABORATORY	0	27,959,879	0.000000	0.000000	5,462,590	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1,161,320	0.000000	0.000000	530,123	63.00
65.00	06500 RESPIRATORY THERAPY	0	4,100,993	0.000000	0.000000	2,300,758	65.00
66.00	06600 PHYSICAL THERAPY	0	3,150,741	0.000000	0.000000	965,400	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	444,518	0.000000	0.000000	112,805	67.00
68.00	06800 SPEECH PATHOLOGY	0	345,024	0.000000	0.000000	111,595	68.00
69.00	06900 ELECTROCARDIOLOGY	0	10,127,660	0.000000	0.000000	2,043,375	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,248,572	0.000000	0.000000	4,554,137	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6,152,044	0.000000	0.000000	2,478,710	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	22,417,022	0.000000	0.000000	7,356,246	73.00
76.00	03020 SLEEP LAB	0	1,601,278	0.000000	0.000000	5,466	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,188,135	0.000000	0.000000	522	90.00
91.00	09100 EMERGENCY	0	28,707,304	0.000000	0.000000	2,557,065	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,668,887	0.000000	0.000000	265,185	92.00
200.00	Total (lines 50-199)	0	223,829,512			40,087,895	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part IV Date/Time Prepared: 9/19/2014 2:54 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	8,294,337	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	126,621	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,864,617	0	54.00
56.00	05600 RADIOISOTOPE	0	1,846,086	0	56.00
57.00	05700 CT SCAN	0	6,870,111	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,703,339	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	781,031	0	59.00
60.00	06000 LABORATORY	0	1,190,930	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	231,769	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	161,564	0	65.00
66.00	06600 PHYSICAL THERAPY	0	6,318	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	588	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,902,449	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,111,728	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	540,609	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,035,249	0	73.00
76.00	03020 SLEEP LAB	0	465,009	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	89,591	0	90.00
91.00	09100 EMERGENCY	0	4,402,947	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	957,896	0	92.00
200.00	Total (lines 50-199)	0	38,582,789	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part V Date/Time Prepared: 9/19/2014 2:54 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.131347	8,294,337	0	0	1,089,436 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.536848	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.330205	126,621	0	0	41,811 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207087	3,864,617	0	0	800,312 54.00
56.00	05600 RADIOISOTOPE	0.100401	1,846,086	0	0	185,349 56.00
57.00	05700 CT SCAN	0.029451	6,870,111	0	0	202,332 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.062196	1,703,339	0	0	105,941 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.227089	781,031	0	0	177,364 59.00
60.00	06000 LABORATORY	0.125705	1,190,930	2,014	0	149,706 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.627550	231,769	0	0	145,447 63.00
65.00	06500 RESPIRATORY THERAPY	0.210132	161,564	0	0	33,950 65.00
66.00	06600 PHYSICAL THERAPY	0.309340	6,318	0	0	1,954 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.310633	588	0	0	183 67.00
68.00	06800 SPEECH PATHOLOGY	0.850932	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.104066	2,902,449	0	0	302,046 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.400024	1,111,728	0	0	444,718 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.425434	540,609	45,750	0	229,993 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.184639	3,035,249	0	0	560,425 73.00
76.00	03020 SLEEP LAB	0.017448	465,009	0	0	8,113 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.238272	89,591	0	0	21,347 90.00
91.00	09100 EMERGENCY	0.149060	4,402,947	0	0	656,303 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.632559	957,896	0	0	605,926 92.00
200.00	Subtotal (see instructions)		38,582,789	47,764	0	5,762,656 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		38,582,789	47,764	0	5,762,656 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet D Part V Date/Time Prepared: 9/19/2014 2:54 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	253	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	19,464	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 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)	19,717	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	19,717	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet D-1 Date/Time Prepared: 9/19/2014 2:54 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			15,738 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			15,738 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			13,034 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)			7,257 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			13,507,536 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			13,507,536 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			13,507,536 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)			858.28 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,228,538 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			6,228,538 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140120		Period: From 05/01/2013 To 04/30/2014		Worksheet D-1 Date/Time Prepared: 9/19/2014 2:54 pm	
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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	2,501,565	1,596	1,567.40	676	1,059,562	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					8,377,722	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,665,822	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)					565,893	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					618,825	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,184,718	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,481,104	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,704	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					858.28	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,320,789	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140120		Period: From 05/01/2013 To 04/30/2014		Worksheet D-1 Date/Time Prepared: 9/19/2014 2:54 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,074,583	13,507,536	0.079554	2,320,789	184,628	90.00
91.00	Nursing School cost	0	13,507,536	0.000000	2,320,789	0	91.00
92.00	Allied health cost	0	13,507,536	0.000000	2,320,789	0	92.00
93.00	All other Medical Education	0	13,507,536	0.000000	2,320,789	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet D-3 Date/Time Prepared: 9/19/2014 2:54 pm	
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		11,210,256		30.00
31.00	03100 INTENSIVE CARE UNIT		1,836,843		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.131347	4,980,159	654,129	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.536848	12,891	6,921	52.00
53.00	05300 ANESTHESIOLOGY	0.330205	94,387	31,167	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207087	2,044,520	423,394	54.00
56.00	05600 RADIOISOTOPE	0.100401	751,882	75,490	56.00
57.00	05700 CT SCAN	0.029451	2,336,032	68,798	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.062196	395,398	24,592	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.227089	728,649	165,468	59.00
60.00	06000 LABORATORY	0.125705	5,462,590	686,675	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.627550	530,123	332,679	63.00
65.00	06500 RESPIRATORY THERAPY	0.210132	2,300,758	483,463	65.00
66.00	06600 PHYSICAL THERAPY	0.309340	965,400	298,637	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.310633	112,805	35,041	67.00
68.00	06800 SPEECH PATHOLOGY	0.850932	111,595	94,960	68.00
69.00	06900 ELECTROCARDIOLOGY	0.104066	2,043,375	212,646	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.400024	4,554,137	1,821,764	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.425434	2,478,710	1,054,528	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.184639	7,356,246	1,358,250	73.00
76.00	03020 SLEEP LAB	0.017448	5,466	95	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.238272	522	124	90.00
91.00	09100 EMERGENCY	0.149060	2,557,065	381,156	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.632559	265,185	167,745	92.00
200.00	Total (sum of lines 50-94 and 96-98)		40,087,895	8,377,722	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		40,087,895		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet E
Part A
Date/Time Prepared:
9/19/2014 2:54 pm

		Title XVIII		Hospital		PPS
		0	before 1/1	on/after 1/1	2.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS						
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, 2013 (see instructions)		4,011,543			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		5,616,159			1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0			1.03
2.00	Outlier payments for discharges. (see instructions)		376,689			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		92.49			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) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 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
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
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00
Disproportionate Share Adjustment						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.89			30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.85			31.00
32.00	Sum of lines 30 and 31		20.74			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part A Date/Time Prepared: 9/19/2014 2:54 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		6.33	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		342,807		34.00
			Prior to October 1		On/After October 1
		0	1.00	1.01	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)				9,046,380 35.00
35.01	Factor 3 (see instructions)				0.000076311 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				690,341 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				400,965 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		400,965		36.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
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 and 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)		0		46.00
47.00	Subtotal (see instructions)		10,748,163		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		10,748,163		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		789,368		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		11,537,531		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		11,537,531		61.00
62.00	Deductibles billed to program beneficiaries		1,299,168		62.00
63.00	Coinurance billed to program beneficiaries		49,264		63.00
64.00	Allowable bad debts (see instructions)		251,880		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		163,722		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		203,037		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		10,352,821		67.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part A Date/Time Prepared: 9/19/2014 2:54 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (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
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-18,737		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-87,264		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,246,820		71.00
71.01	Sequestration adjustment (see instructions)		204,936		71.01
72.00	Interim payments		9,992,123		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		49,761		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		14,081		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part 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		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet E Part B Date/Time Prepared: 9/19/2014 2:54 pm
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			19,717 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			5,762,656 2.00
3.00	PPS payments			5,479,059 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 Worksheet D, Part IV, column 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)			19,717 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			47,764 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			47,764 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 charge basis 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)			47,764 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			28,047 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)			19,717 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			5,479,059 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			9,150 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,360,686 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			4,128,940 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			4,128,940 30.00
31.00	Primary payer payments			105 31.00
32.00	Subtotal (line 30 minus line 31)			4,128,835 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			276,029 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			179,419 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			244,441 36.00
37.00	Subtotal (see instructions)			4,308,254 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	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)			4,308,254 40.00
40.01	Sequestration adjustment (see instructions)			86,165 40.01
41.00	Interim payments			4,183,469 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			38,620 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet E-1
Part I
Date/Time Prepared:
9/19/2014 2:54 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		9,960,022		4,154,613	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/23/2013	32,101	12/23/2013	28,856	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		32,101		28,856	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9,992,123		4,183,469	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		49,761		38,620	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		10,041,884		4,222,089	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet E-1 Part II Date/Time Prepared: 9/19/2014 2:54 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			3,424 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			7,933 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			1,872 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			14,630 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			251,337,669 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			6,255,253 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,265,492 8.00
9.00	Sequestration adjustment amount (see instructions)			25,310 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,240,182 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,305,236 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)			-65,054 32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet G

Date/Time Prepared:
9/19/2014 2:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,200,074	0	0	0	1.00
2.00	Temporary investments	501,905	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,481,502	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,311,000	0	0	0	6.00
7.00	Inventory	1,005,099	0	0	0	7.00
8.00	Prepaid expenses	1,471,371	0	0	0	8.00
9.00	Other current assets	1,955,132	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)	19,304,083	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	-1,646,465	0	0	0	14.00
15.00	Buildings	11,585,946	0	0	0	15.00
16.00	Accumulated depreciation	-8,730,769	0	0	0	16.00
17.00	Leasehold improvements	19,686,815	0	0	0	17.00
18.00	Accumulated depreciation	-15,116,471	0	0	0	18.00
19.00	Fixed equipment	18,173,061	0	0	0	19.00
20.00	Accumulated depreciation	-12,279,701	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	29,882,991	0	0	0	23.00
24.00	Accumulated depreciation	-22,029,350	0	0	0	24.00
25.00	Minor equipment depreciable	1,565,356	0	0	0	25.00
26.00	Accumulated depreciation	-825,964	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	661,469	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,203,715	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	23,709,740	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,152,037	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,861,777	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	70,369,575	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,970,667	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	3,373,890	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	2,878,755	0	0	0	43.00
44.00	Other current liabilities	3,633,635	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,856,947	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,535,972	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,544,811	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,080,783	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,937,730	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	38,431,845				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)	38,431,845	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	70,369,575	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet G-1

Date/Time Prepared:
9/19/2014 2:54 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		32,320,152		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,230,403			2.00
3.00	Total (sum of line 1 and line 2)		38,550,555		0	3.00
4.00	CHANGES IN MINIMUM PENSION LIABILITY	2,374,850		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		2,374,850		0	10.00
11.00	Subtotal (line 3 plus line 10)		40,925,405		0	11.00
12.00	DECREASE IN RESTRICTED ASSETS	216,950		0		12.00
13.00	TRANSFER TO AFFILIATES	2,276,610		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		2,493,560		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		38,431,845		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	CHANGES IN MINIMUM PENSION LIABILITY		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	DECREASE IN RESTRICTED ASSETS		0			12.00
13.00	TRANSFER TO AFFILIATES		0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/19/2014 2:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	22,158,671		22,158,671	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,158,671		22,158,671	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,915,207		3,915,207	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)	3,915,207		3,915,207	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	26,073,878		26,073,878	17.00
18.00	Ancillary services	70,475,420	122,216,329	192,691,749	18.00
19.00	Outpatient services	4,947,810	28,823,706	33,771,516	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		1,610,531	1,610,531	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PROFESSIONAL FEES	881,627	1,231,780	2,113,407	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	102,378,735	153,882,346	256,261,081	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		64,328,172		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		64,328,172		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140120

Period:
From 05/01/2013
To 04/30/2014

Worksheet G-3

Date/Time Prepared:
9/19/2014 2:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	256,261,081	1.00
2.00	Less contractual allowances and discounts on patients' accounts	191,357,200	2.00
3.00	Net patient revenues (line 1 minus line 2)	64,903,881	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	64,328,172	4.00
5.00	Net income from service to patients (line 3 minus line 4)	575,709	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	12,877	6.00
7.00	Income from investments	1,461,454	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	161	13.00
14.00	Revenue from meals sold to employees and guests	542,952	14.00
15.00	Revenue from rental of living quarters	34,320	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	77,326	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN ON INVESTMENTS	1,182,200	24.00
24.01	WELLNESS CENTER	17,366	24.01
24.02	INVESTMENT INCOME ON SI TRUST	253,746	24.02
24.03	MISCELLANEOUS INCOME	24,852	24.03
24.04	EHR FUNDS	2,059,251	24.04
25.00	Total other income (sum of lines 6-24)	5,666,505	25.00
26.00	Total (line 5 plus line 25)	6,242,214	26.00
27.00	LOSS ON ASSET DISPOSAL	11,811	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	11,811	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,230,403	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140120

Period: From 05/01/2013

Worksheet H

HHA CCN: 147057

To 04/30/2014

Date/Time Prepared: 9/19/2014 2:54 pm

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		14,000	14,000	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	6,503	6,503	3.00
4.00	0	0	0	0	0	0	4.00
5.00	103,226	0	25,825	4,115	46,618	179,784	5.00
HHA REIMBURSABLE SERVICES							
6.00	333,337	0	0	0	0	333,337	6.00
7.00	0	0	0	235,628	0	235,628	7.00
8.00	0	0	0	18,854	0	18,854	8.00
9.00	0	0	0	6,633	0	6,633	9.00
10.00	101	0	0	0	0	101	10.00
11.00	30,540	0	0	0	0	30,540	11.00
12.00	0	0	0	3,600	13,695	17,295	12.00
13.00	0	0	0	0	476	476	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	467,204	0	25,825	268,830	81,292	843,151	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	0	14,000	0	14,000			1.00
2.00	0	0	0	0			2.00
3.00	43	6,546	0	6,546			3.00
4.00	0	0	0	0			4.00
5.00	-3,789	175,995	0	175,995			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	333,337	0	333,337			6.00
7.00	0	235,628	0	235,628			7.00
8.00	0	18,854	0	18,854			8.00
9.00	0	6,633	0	6,633			9.00
10.00	0	101	0	101			10.00
11.00	0	30,540	0	30,540			11.00
12.00	-10,095	7,200	0	7,200			12.00
13.00	185	661	0	661			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	-13,656	829,495	0	829,495			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet H-1 Part I Date/Time Prepared: 9/19/2014 2:54 pm
		HHA CCN: 147057	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bl dgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	14,000	14,000			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	6,546	0	0	6,546	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	175,995	14,000	0	6,546	0	196,541
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	333,337	0	0	0	0	333,337
7.00	Physical Therapy	235,628	0	0	0	0	235,628
8.00	Occupational Therapy	18,854	0	0	0	0	18,854
9.00	Speech Pathology	6,633	0	0	0	0	6,633
10.00	Medical Social Services	101	0	0	0	0	101
11.00	Home Health Aide	30,540	0	0	0	0	30,540
12.00	Supplies (see instructions)	7,200	0	0	0	0	7,200
13.00	Drugs	661	0	0	0	0	661
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	829,495	14,000	0	6,546	0	829,495
		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	196,541					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	103,506	436,843				6.00
7.00	Physical Therapy	73,166	308,794				7.00
8.00	Occupational Therapy	5,854	24,708				8.00
9.00	Speech Pathology	2,060	8,693				9.00
10.00	Medical Social Services	31	132				10.00
11.00	Home Health Aide	9,483	40,023				11.00
12.00	Supplies (see instructions)	2,236	9,436				12.00
13.00	Drugs	205	866				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		829,495				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet H-1 Part II Date/Time Prepared: 9/19/2014 2:54 pm
		HHA CCN: 147057	Home Health Agency I	PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,000			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	2,000	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	2,000	0	2,000	0	-196,541	632,954
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	333,337
7.00	Physical Therapy	0	0	0	0	0	235,628
8.00	Occupational Therapy	0	0	0	0	0	18,854
9.00	Speech Pathology	0	0	0	0	0	6,633
10.00	Medical Social Services	0	0	0	0	0	101
11.00	Home Health Aide	0	0	0	0	0	30,540
12.00	Supplies (see instructions)	0	0	0	0	0	7,200
13.00	Drugs	0	0	0	0	0	661
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	2,000	0	2,000	0	-196,541	632,954
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	14,000	0	6,546	0		196,541
26.00	Unit Cost Multiplier	7.000000	0.000000	3.273000	0.000000		0.310514

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120

Period: From 05/01/2013

Worksheet H-2

HHA CCN: 147057

To 04/30/2014

Part I
Date/Time Prepared: 9/19/2014 2:54 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
1.00 Administrative and General	0	0	9,128	23,861	32,989	9,065	1.00	
2.00 Skilled Nursing Care	436,843	0	0	77,053	513,896	141,219	2.00	
3.00 Physical Therapy	308,794	0	0	0	308,794	84,857	3.00	
4.00 Occupational Therapy	24,708	0	0	0	24,708	6,790	4.00	
5.00 Speech Pathology	8,693	0	0	0	8,693	2,389	5.00	
6.00 Medical Social Services	132	0	0	23	155	43	6.00	
7.00 Home Health Aide	40,023	0	0	7,060	47,083	12,938	7.00	
8.00 Supplies (see instructions)	9,436	0	0	0	9,436	2,593	8.00	
9.00 Drugs	866	0	0	43	909	250	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	829,495	0	9,128	108,040	946,663	260,144	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.00	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	0	0	0	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140120

Period: From 05/01/2013

Worksheet H-2

HHA CCN: 147057

To 04/30/2014

Part I
Date/Time Prepared:
9/19/2014 2:54 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	370	0	0	42,424	0	42,424	1.00
2.00	Skilled Nursing Care	0	0	0	655,115	0	655,115	2.00
3.00	Physical Therapy	0	0	0	393,651	0	393,651	3.00
4.00	Occupational Therapy	0	0	0	31,498	0	31,498	4.00
5.00	Speech Pathology	0	0	0	11,082	0	11,082	5.00
6.00	Medical Social Services	0	0	0	198	0	198	6.00
7.00	Home Health Aide	0	0	0	60,021	0	60,021	7.00
8.00	Supplies (see instructions)	0	0	0	12,029	0	12,029	8.00
9.00	Drugs	0	106	0	1,265	0	1,265	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	370	106	0	1,207,283	0	1,207,283	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	23,859	678,974					2.00
3.00	Physical Therapy	14,337	407,988					3.00
4.00	Occupational Therapy	1,147	32,645					4.00
5.00	Speech Pathology	404	11,486					5.00
6.00	Medical Social Services	7	205					6.00
7.00	Home Health Aide	2,186	62,207					7.00
8.00	Supplies (see instructions)	438	12,467					8.00
9.00	Drugs	46	1,311					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	42,424	1,207,283					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.	0.036420						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120
HHA CCN: 147057

Period: From 05/01/2013 To 04/30/2014

Worksheet H-2 Part II
Date/Time Prepared: 9/19/2014 2:54 pm

Home Health Agency I

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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	8,969	103,226	0	32,989	0	1.00
2.00 Skilled Nursing Care	0	0	333,337	0	513,896	0	2.00
3.00 Physical Therapy	0	0	0	0	308,794	0	3.00
4.00 Occupational Therapy	0	0	0	0	24,708	0	4.00
5.00 Speech Pathology	0	0	0	0	8,693	0	5.00
6.00 Medical Social Services	0	0	101	0	155	0	6.00
7.00 Home Health Aide	0	0	30,540	0	47,083	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	9,436	0	8.00
9.00 Drugs	0	0	185	0	909	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	8,969	467,389		946,663	0	20.00
21.00 Total cost to be allocated	0	9,128	108,040		260,144	0	21.00
22.00 Unit cost multiplier	0.000000	1.017728	0.231156		0.274801	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	0	0	0	0	4,699	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	0	4,699	20.00
21.00 Total cost to be allocated	0	0	0	0	0	370	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.078740	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140120
HHA CCN: 147057

Period:
From 05/01/2013
To 04/30/2014

Worksheet H-2
Part II
Date/Time Prepared:
9/19/2014 2:54 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	476	0		9.00
10.00 DME	0	0		10.00
11.00 Home Dialysis Aide Services	0	0		11.00
12.00 Respiratory Therapy	0	0		12.00
13.00 Private Duty Nursing	0	0		13.00
14.00 Clinic	0	0		14.00
15.00 Health Promotion Activities	0	0		15.00
16.00 Day Care Program	0	0		16.00
17.00 Home Delivered Meals Program	0	0		17.00
18.00 Homemaker Service	0	0		18.00
19.00 All Others (specify)	0	0		19.00
20.00 Total (sum of lines 1-19)	476	0		20.00
21.00 Total cost to be allocated	106	0		21.00
22.00 Unit cost multiplier	0.222689	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet H-3 Part I Date/Time Prepared: 9/19/2014 2:54 pm
		HHA CCN: 147057	Title XVIII	Home Health Agency I PPS

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	678,974		678,974	3,609	188.13	1.00
2.00	Physical Therapy	3.00	407,988	0	407,988	3,531	115.54	2.00
3.00	Occupational Therapy	4.00	32,645	0	32,645	237	137.74	3.00
4.00	Speech Pathology	5.00	11,486	0	11,486	74	155.22	4.00
5.00	Medical Social Services	6.00	205		205	1	205.00	5.00
6.00	Home Health Aide	7.00	62,207		62,207	461	134.94	6.00
7.00	Total (sum of lines 1-6)		1,193,505	0	1,193,505	7,913		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		37900	718	1,476		8.00
8.01	Skilled Nursing Care		99914	31	199		8.01
9.00	Physical Therapy		37900	583	1,359		9.00
9.01	Physical Therapy		99914	19	161		9.01
10.00	Occupational Therapy		37900	56	116		10.00
10.01	Occupational Therapy		99914	0	5		10.01
11.00	Speech Pathology		37900	8	39		11.00
11.01	Speech Pathology		99914	0	8		11.01
12.00	Medical Social Services		37900	0	0		12.00
12.01	Medical Social Services		99914	0	0		12.01
13.00	Home Health Aide		37900	87	220		13.00
13.01	Home Health Aide		99914	0	23		13.01
14.00	Total (sum of lines 8-13)			1,502	3,606		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (From HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	12,467	3,025	15,492	7,561	2.048935	15.00
16.00	Cost of Drugs	9.00	1,311	0	1,311	1,232	1.064123	16.00
Cost Center Description	Part A	Program Visits		Part A	Cost of Services	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	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	749	1,675		140,909	315,118	1.00
2.00	Physical Therapy	602	1,520		69,555	175,621	2.00
3.00	Occupational Therapy	56	121		7,713	16,667	3.00
4.00	Speech Pathology	8	47		1,242	7,295	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	87	243		11,740	32,790	6.00
7.00	Total (sum of lines 1-6)	1,502	3,606		231,159	547,491	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 140120 HHA CCN: 147057	Period: From 05/01/2013 To 04/30/2014	Worksheet H-3 Part I Date/Time Prepared: 9/19/2014 2:54 pm
			Title XVII I	Home Health Agency I	PPS

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 A	Part B		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		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						15.00
16.00	Cost of Drugs		236	0		251	16.00
Cost Center Description		Total Program Cost (sum of col.s. 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	456,027					1.00
2.00	Physical Therapy	245,176					2.00
3.00	Occupational Therapy	24,380					3.00
4.00	Speech Pathology	8,537					4.00
5.00	Medical Social Services	0					5.00
6.00	Home Health Aide	44,530					6.00
7.00	Total (sum of lines 1-6)	778,650					7.00
Cost Center Description		12.00					
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140120	Period: From 05/01/2013	Worksheet H-3
		HHA CCN: 147057	To 04/30/2014	Part II
		Title XVIII	Home Health Agency I	Date/Time Prepared: 9/19/2014 2:54 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	0.309340	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.310633	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.850932	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.400024	7,561	3,025	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.184639	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140120 HHA CCN: 147057	Period: From 05/01/2013 To 04/30/2014	Worksheet H-4 Part I-11 Date/Time Prepared: 9/19/2014 2:54 pm
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	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	251	0
2.00	Total charges	0	236	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	236	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	15	0
9.00	Primary payer amounts	0	0	0
			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	251
11.00	Total PPS Reimbursement - Full Episodes without Outliers		235,559	590,501
12.00	Total PPS Reimbursement - Full Episodes with Outliers		4,813	0
13.00	Total PPS Reimbursement - LUPA Episodes		1,419	7,590
14.00	Total PPS Reimbursement - PEP Episodes		2,169	5,701
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		522	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		244,482	604,043
23.00	Excess reasonable cost (from line 8)		0	15
24.00	Subtotal (line 22 minus line 23)		244,482	604,028
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		244,482	604,028
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		244,482	604,028
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		244,482	604,028
31.01	Sequestration adjustment (see instructions)		4,890	12,081
32.00	Interim payments (see instructions)		239,592	591,832
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	115
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 140120
HHA CCN: 147057

Period:
From 05/01/2013
To 04/30/2014

Worksheet H-5
Date/Time Prepared:
9/19/2014 2:54 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		239,592		591,832	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)		239,592		591,832	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		115	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		239,592		591,947	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140120	Period: From 05/01/2013 To 04/30/2014	Worksheet L Parts I-III Date/Time Prepared: 9/19/2014 2:54 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		758,650	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		30,718	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)		40.32	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		789,368	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