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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140040	Period: From 05/01/2014 To 04/30/2015	Worksheet S Parts I-III Date/Time Prepared: 9/29/2015 9:24 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/29/2015 Time: 9:24 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GALESBURG COTTAGE HOSPITAL (140040) for the cost reporting period beginning 05/01/2014 and ending 04/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	349,802	-56,457	-143,261	0	1.00
2.00	Subprovider - IPF	0	9,323	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	6,030	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	365,155	-56,457	-143,261	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/29/2015 9:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 695 NORTH KELLOGG STREET	PO Box:			1.00
2.00	City: GALESBURG	State: IL	Zip Code: 61401	County: KNOX	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GALESBURG COTTAGE HOSPITAL	140040	99914	1	07/06/1966	N	P	P	3.00
4.00	Subprovider - IPF	GALEBSURG COTTAGE PSYCH	14S040	99914	4	05/01/2006	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GALESBURG COTTAGE SKILLED UNIT	145690	99914		01/11/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2014	04/30/2015	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,022	306	9	0	709	85	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/29/2015 9:22 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1		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.	05/01/2014	04/30/2015	38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/29/2015 9:22 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/29/2015 9:22 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/29/2015 9:22 am

		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)			106.00
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 Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. 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)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	56,229	258,254	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/29/2015 9:22 am

		1.00	2.00	
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	449008	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BOULEVARD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y	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, § 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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140040	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/29/2015 9:22 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/01/2014	06/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/29/2015 9:22 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for 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.			N	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	08/25/2015	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 9/29/2015 9:22 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	Y	12/31/2014	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AMBER	WALKER	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-3331	AMBER_WALKER@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/29/2015 9:22 am

		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)	08/25/2015			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.		REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/29/2015 9:22 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	84	30,660	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		84	30,660	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		96	35,040	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	34	12,410		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	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
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		142				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 9/29/2015 9:22 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,581	865	8,215			1.00
2.00	HMO and other (see instructions)	1,631	609				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)	4,581	865	8,215			7.00
8.00	INTENSIVE CARE UNIT	1,269	153	2,002			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		419	834			13.00
14.00	Total (see instructions)	5,850	1,437	11,051	0.00	327.55	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,675	7	2,255	0.00	12.54	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,022	0	5,200	0.00	26.56	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	366.65	27.00
28.00	Observation Bed Days		0	865			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	85	143			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/29/2015 9:22 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,104	488	2,388	1.00
2.00	HMO and other (see instructions)			0	0		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	1,104	488	2,388	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	137	9	183	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	0.00					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
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 9/29/2015 9:22 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	19,734,160	0	19,734,160	762,639.00	25.88	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,336,425	0	1,336,425	55,252.00	24.19	9.00
10.00	Excluded area salaries (see instructions)		829,215	21,930	851,145	30,374.00	28.02	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,791,722	0	1,791,722	40,388.00	44.36	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		114,070	0	114,070	1,077.00	105.91	13.00
14.00	Home office salaries & wage-related costs		1,327,607	0	1,327,607	25,515.00	52.03	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)		5,112,801	0	5,112,801			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		354,786	0	354,786			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	114,451	0	114,451	5,274.00	21.70	26.00
27.00	Administrative & General	5.00	2,298,205	-173,590	2,124,615	91,092.00	23.32	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	432,328	0	432,328	19,736.00	21.91	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	579,058	0	579,058	46,829.00	12.37	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		880,806	0	880,806	60,703.00	14.51	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,146,918	85,112	1,232,030	37,293.00	33.04	38.00
39.00	Central Services and Supply	14.00	133,492	0	133,492	9,735.00	13.71	39.00
40.00	Pharmacy	15.00	650,853	0	650,853	20,304.00	32.06	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 9/29/2015 9:22 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	424,008	0	424,008	23,253.00	18.23	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 9/29/2015 9:22 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		20,614,966	0	20,614,966	823,342.00	25.04	1.00
2.00	Excluded area salaries (see instructions)		2,165,640	21,930	2,187,570	85,626.00	25.55	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,449,326	-21,930	18,427,396	737,716.00	24.98	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,233,399	0	3,233,399	66,980.00	48.27	4.00
5.00	Subtotal wage-related costs (see inst.)		5,112,801	0	5,112,801	0.00	27.75	5.00
6.00	Total (sum of lines 3 thru 5)		26,795,526	-21,930	26,773,596	804,696.00	33.27	6.00
7.00	Total overhead cost (see instructions)		6,660,119	-88,478	6,571,641	314,219.00	20.91	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 9/29/2015 9:22 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	336,670	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,243,418	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	27,553	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	17,208	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-87	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	16,690	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	290,801	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	1,124,770	17.00
18.00	Medicare Taxes - Employers Portion Only	263,051	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	132,891	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,452,965	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	14,621	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 9/29/2015 9:22 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-7 | Date/Time Prepared: 9/29/2015 9:22 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	5	0	5	11.00
12.00		RUC	32	0	32	12.00
13.00		RUB	49	0	49	13.00
14.00		RUA	32	0	32	14.00
15.00		RVC	378	0	378	15.00
16.00		RVB	237	0	237	16.00
17.00		RVA	352	0	352	17.00
18.00		RHC	657	0	657	18.00
19.00		RHB	381	0	381	19.00
20.00		RHA	667	0	667	20.00
21.00		RMC	227	0	227	21.00
22.00		RMB	79	0	79	22.00
23.00		RMA	205	0	205	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	3	0	3	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	7	0	7	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	223	0	223	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	138	0	138	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	99	0	99	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	65	0	65	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	34	0	34	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	30	0	30	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	27	0	27	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	22	0	22	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	27	0	27	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	24	0	24	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-7 | Date/Time Prepared: 9/29/2015 9:22 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	5	0	5	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	4	0	4	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	5	0	5	78.00
199.00		AAA	8	0	8	199.00
200.00	TOTAL		4,022	0	4,022	200.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,837,817			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-10 | Date/Time Prepared: 9/29/2015 9:22 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.140267	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,692,226	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Yes	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	No	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	6,742,535	5.00
6.00	Medicaid charges	65,173,352	6.00
7.00	Medicaid cost (line 1 times line 6)	9,141,671	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	20,995	9.00
10.00	Stand-alone SCHIP charges	516,394	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	72,433	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	51,438	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)	51,438	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	13,301	3,740	17,041	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,866	525	2,391	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)	1,866	525	2,391	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?	No	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)	2,269,126	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	234,670	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,034,456	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	285,367	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	287,758	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	339,196	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,368,774	1,368,774	568,316	1,937,090	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,995,377	2,995,377	497,415	3,492,792	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	114,451	199,639	314,090	3,937,352	4,251,442	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,298,205	16,846,605	19,144,810	-4,947,499	14,197,311	5.00
7.00	00700	OPERATION OF PLANT	432,328	1,369,581	1,801,909	0	1,801,909	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	190,515	190,515	0	190,515	8.00
9.00	00900	HOUSEKEEPING	579,058	269,099	848,157	0	848,157	9.00
10.00	01000	DIETARY	0	931,171	931,171	-482,438	448,733	10.00
11.00	01100	CAFETERIA	0	0	0	482,048	482,048	11.00
13.00	01300	NURSING ADMINISTRATION	1,146,918	202,360	1,349,278	85,396	1,434,674	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	133,492	2,723,717	2,857,209	-2,347,722	509,487	14.00
15.00	01500	PHARMACY	650,853	2,203,618	2,854,471	-2,055,616	798,855	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	424,008	403,079	827,087	-8,870	818,217	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,464,680	938,373	3,403,053	653,080	4,056,133	30.00
31.00	03100	INTENSIVE CARE UNIT	1,375,479	342,482	1,717,961	-1,691	1,716,270	31.00
40.00	04000	SUBPROVIDER - IPF	727,866	510,517	1,238,383	-1,899	1,236,484	40.00
43.00	04300	NURSERY	0	722	722	345,798	346,520	43.00
44.00	04400	SKILLED NURSING FACILITY	1,336,425	294,051	1,630,476	-6,010	1,624,466	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,182,974	995,267	2,178,241	400,918	2,579,159	50.00
51.00	05100	RECOVERY ROOM	394,140	43,683	437,823	-437,823	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	915,132	423,389	1,338,521	-1,007,017	331,504	52.00
53.00	05300	ANESTHESIOLOGY	1,145,733	307,798	1,453,531	0	1,453,531	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	691,037	780,536	1,471,573	739,333	2,210,906	54.00
54.01	05401	ULTRASOUND	102,012	21,870	123,882	-123,882	0	54.01
56.00	05600	RADIOISOTOPE	91,146	218,201	309,347	-309,347	0	56.00
57.00	05700	CT SCAN	145,095	204,173	349,268	-349,268	0	57.00
58.00	05800	MRI	113,433	38,862	152,295	-152,295	0	58.00
60.00	06000	LABORATORY	1,045,820	1,581,693	2,627,513	-60,086	2,567,427	60.00
65.00	06500	RESPIRATORY THERAPY	378,891	124,224	503,115	81,402	584,517	65.00
66.00	06600	PHYSICAL THERAPY	0	612,373	612,373	334,474	946,847	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	236,626	236,626	-236,626	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	97,848	97,848	-97,848	0	68.00
69.00	06900	ELECTROCARDIOLOGY	490,067	304,848	794,915	-979	793,936	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	828,607	828,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,531,462	1,531,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,952,343	1,952,343	73.00
74.00	07400	RENAL DIALYSIS	0	96,243	96,243	0	96,243	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	66,310	37,336	103,646	-103,646	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	149,726	522,286	672,012	-1,777	670,235	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,037,532	1,073,843	2,111,375	1,409,955	3,521,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	66,548	1,348,051	1,414,599	-1,414,599	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,699,359	40,858,830	60,558,189	-299,039	60,259,150	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,245	103,977	136,222	0	136,222	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	299,039	299,039	194.01
194.02	07952	SENIOR CIRCLE	2,556	21,922	24,478	0	24,478	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	19,734,160	40,984,729	60,718,889	0	60,718,889	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,359,923	3,297,013		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-752,904	2,739,888		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-8,399	4,243,043		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,258,311	6,939,000		5.00
7.00	00700	OPERATION OF PLANT	-13,653	1,788,256		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	190,515		8.00
9.00	00900	HOUSEKEEPING	0	848,157		9.00
10.00	01000	DIETARY	0	448,733		10.00
11.00	01100	CAFETERIA	0	482,048		11.00
13.00	01300	NURSING ADMINISTRATION	-4,290	1,430,384		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	509,487		14.00
15.00	01500	PHARMACY	0	798,855		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,591	814,626		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-105,130	3,951,003		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,716,270		31.00
40.00	04000	SUBPROVIDER - IPF	-164,594	1,071,890		40.00
43.00	04300	NURSERY	0	346,520		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,624,466		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,579,159		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	331,504		52.00
53.00	05300	ANESTHESIOLOGY	-2,000	1,451,531		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,210,906		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-91,575	2,475,852		60.00
65.00	06500	RESPIRATORY THERAPY	0	584,517		65.00
66.00	06600	PHYSICAL THERAPY	0	946,847		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	793,936		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17	828,624		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,531,462		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-568	1,951,775		73.00
74.00	07400	RENAL DIALYSIS	0	96,243		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	670,235		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-1,835,389	1,685,941		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,880,464	51,378,686		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	136,222		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	299,039		194.01
194.02	07952	SENIOR CIRCLE	0	24,478		194.02
194.03	07953	UNUSED SPACE	0	0		194.03
194.04	07954	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-8,880,464	51,838,425		200.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/29/2015 9:22 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,939,089	1.00
	0		0	3,939,089	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	147,950	1.00
	0		0	147,950	
	C - RENTAL AND LEASE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	491,899	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
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	0		0	491,899	
	D - OTHER CAP COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	92,267	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	476,049	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,516	3.00
	0		0	573,832	
	E - MARKETING DEPT				
1.00	MARKETING	194.01	88,478	210,561	1.00
	0		88,478	210,561	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	680,657	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,531,462	2.00
	0		0	2,212,119	
	G - COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,952,343	1.00
	0		0	1,952,343	
	H - LABOR AND DELIV				
1.00	ADULTS & PEDIATRICS	30.00	451,102	208,540	1.00
2.00	NURSERY	43.00	236,603	109,195	2.00
	0		687,705	317,735	
	I - THERAPY COSTS				
1.00	PHYSICAL THERAPY	66.00	0	334,474	1.00
2.00		0.00	0	0	2.00
	0		0	334,474	
	J - MISCELLANEOUS DEPTS				
1.00	NURSING ADMINISTRATION	13.00	85,112	8,471	1.00
2.00	OPERATING ROOM	50.00	394,140	42,786	2.00
3.00	RESPIRATORY THERAPY	65.00	66,310	37,336	3.00
4.00	EMERGENCY	91.00	66,548	1,348,051	4.00
	0		612,110	1,436,644	
	K - OTHER RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	451,686	482,153	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		451,686	482,153	
	L - DIETARY TO CAFETERIA				
1.00	CAFETERIA	11.00	0	482,048	1.00
	0		0	482,048	
500.00	Grand Total: Increases		1,839,979	12,580,847	500.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/29/2015 9:22 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,939,089	0		1.00
	0		0	3,939,089			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	147,950	0		1.00
	0		0	147,950			
	C - RENTAL AND LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,737	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	41,956	10		2.00
3.00	DIETARY	10.00	0	390	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	8,187	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,902	0		5.00
6.00	PHARMACY	15.00	0	103,273	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,870	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	6,562	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	1,691	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	1,899	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	6,010	0		11.00
12.00	OPERATING ROOM	50.00	0	4,759	0		12.00
13.00	RECOVERY ROOM	51.00	0	897	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,577	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	194,506	0		15.00
16.00	MRI	58.00	0	953	0		16.00
17.00	LABORATORY	60.00	0	60,086	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	22,244	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	979	0		19.00
20.00	WOUND CARE	76.03	0	1,777	0		20.00
21.00	EMERGENCY	91.00	0	4,644	0		21.00
	0		0	491,899			
	D - OTHER CAP COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	573,832	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	573,832			
	E - MARKETING DEPT						
1.00	ADMINISTRATIVE & GENERAL	5.00	88,478	210,561	0		1.00
	0		88,478	210,561			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,180,870	0		1.00
2.00	OPERATING ROOM	50.00	0	31,249	0		2.00
	0		0	2,212,119			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	1,952,343	0		1.00
	0		0	1,952,343			
	H - LABOR AND DELIV						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	687,705	317,735	0		1.00
2.00		0.00	0	0	0		2.00
	0		687,705	317,735			
	I - THERAPY COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	0	236,626	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	97,848	0		2.00
	0		0	334,474			
	J - MISCELLANEOUS DEPTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	85,112	8,471	0		1.00
2.00	RECOVERY ROOM	51.00	394,140	42,786	0		2.00
3.00	SLEEP LAB	76.01	66,310	37,336	0		3.00
4.00	AMBULANCE SERVICES	95.00	66,548	1,348,051	0		4.00
	0		612,110	1,436,644			
	K - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	102,012	21,870	0		1.00
2.00	RADIOISOTOPE	56.00	91,146	218,201	0		2.00
3.00	CT SCAN	57.00	145,095	204,173	0		3.00
4.00	MRI	58.00	113,433	37,909	0		4.00
	0		451,686	482,153			
	L - DIETARY TO CAFETERIA						
1.00	DIETARY	10.00	0	482,048	0		1.00
	0		0	482,048			
500.00	Grand Total: Decreases		1,839,979	12,580,847			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 9/29/2015 9:22 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,943,661	0	0	0	0	1.00
2.00	Land Improvements	954,783	31,400	0	31,400	0	2.00
3.00	Buildings and Fixtures	52,909,965	18,400	0	18,400	0	3.00
4.00	Building Improvements	8,766,644	578,301	0	578,301	55,594	4.00
5.00	Fixed Equipment	4,699,102	709,147	0	709,147	32,803	5.00
6.00	Movable Equipment	46,060,037	1,464,635	0	1,464,635	598,020	6.00
7.00	HIT designated Assets	4,333,727	663,706	0	663,706	254,611	7.00
8.00	Subtotal (sum of lines 1-7)	119,667,919	3,465,589	0	3,465,589	941,028	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	119,667,919	3,465,589	0	3,465,589	941,028	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,943,661	0	1.00
2.00	Land Improvements	986,183	0	2.00
3.00	Buildings and Fixtures	52,928,365	0	3.00
4.00	Building Improvements	9,289,351	0	4.00
5.00	Fixed Equipment	5,375,446	0	5.00
6.00	Movable Equipment	46,926,652	0	6.00
7.00	HIT designated Assets	4,742,822	0	7.00
8.00	Subtotal (sum of lines 1-7)	122,192,480	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	122,192,480	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 9/29/2015 9:22 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,368,774	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,995,377	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,364,151	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,368,774		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,995,377		2.00
3.00	Total (sum of lines 1-2)	0	4,364,151		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 9/29/2015 9:22 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	65,147,560	0	65,147,560	0.533155	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	57,044,922	0	57,044,922	0.466845	0	2.00
3.00	Total (sum of lines 1-2)	122,192,482	0	122,192,482	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,846,054	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,146,853	491,899	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,992,907	491,899	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	796,507	92,267	476,049	86,136	3,297,013	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,516	0	95,620	2,739,888	2.00
3.00	Total (sum of lines 1-2)	796,507	97,783	476,049	181,756	6,036,901	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/29/2015 9:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-44,680	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-9,162	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,202,978			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	2,111,345			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others	B	-13,087	CAP REL COSTS-BLDG & FIXT	1.00	14	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	17	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-568	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,591	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-4,220	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	477,280	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-842,166	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	B	-20	ADMINISTRATIVE & GENERAL	5.00	0	33.00
36.00	OTHER MISCELLANEOUS REVENUE	B	-42,522	ADMINISTRATIVE & GENERAL	5.00	0	36.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/29/2015 9:22 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
37.00	DEPRECIATION - ADMIN AND GENERAL	A	-568	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	HOSPITAL BAD DEBT	B	-4,321,529	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	PATIENT PHONES BENEFITS COST	A	-8,399	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	PATIENT PHONES DEPRECIATION COST	A	-17,082	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00	PATIENT TV CABLE EXPENSE	A	-13,653	OPERATION OF PLANT	7.00	0	42.00
43.00	MARKETING EXP - EXCL MARKETING DEPT	A	-223,402	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	ILLINOIS PROVIDER TAX	A	-2,623,321	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	PHYSICIAN RECRUITING	A	-169,816	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-28,014	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	CHARITABLE CONTRIBUTIONS	A	-3,467	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00	PENALTIES	A	-10,000	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	CLUB DUES	A	-3,344	ADMINISTRATIVE & GENERAL	5.00	0	49.00
49.01	MINORITY INTEREST	A	57,210	CAP REL COSTS-BLDG & FIXT	1.00	14	49.01
49.02	NONALLOWABLE LEGAL FEES	A	-33,783	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.06	DOJ SETTLEMENT NONALLOWABLE LEGAL FE	A	-906,944	ADMINISTRATIVE & GENERAL	5.00	0	49.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,880,464				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 9/29/2015 9:22 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED INTEREST	796,507	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	OPERATING INTEREST	25,890	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	426,996	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	27,282	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BLDG AND FIXTU	11,763	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MVABLE EQUIPME	78,095	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HO COSTS	1,126,683	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-2,852,153	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1,856,126	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	PASI FEES	0	376,156	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	2,427	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	314,483	242,463	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	404,846	388,945	4.09
4.10	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	3,985	0	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	42,422	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	635,916	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	20,091	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	96,345	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	0	5,541	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	57,634	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	24,420	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	25,645	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	16,325	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	315,904	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	53,555	4.21
4.22	1.00	CAP REL COSTS-BLDG & FIXT	PRE-ACQ CAPITAL -BLDG & FIXT	2,968	0	4.22
4.23	2.00	CAP REL COSTS-MVBLE EQUIP	PRE-ACQ CAPITAL - MOVEABLE E	17,525	0	4.23
4.24	5.00	ADMINISTRATIVE & GENERAL	PRE-ACQUISITION PERIOD NON-C	182,084	0	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,419,107	1,307,762	5.00

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

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

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

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

6.00	B		0.00	COMMUNITY HEALT	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 9/29/2015 9:22 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	796,507	11		1.00
2.00	25,890	0		2.00
3.00	426,996	0		3.00
4.00	27,282	14		4.00
4.01	11,763	14		4.01
4.02	78,095	14		4.02
4.03	1,126,683	0		4.03
4.04	2,852,153	0		4.04
4.05	-1,856,126	0		4.05
4.06	-376,156	0		4.06
4.07	-2,427	0		4.07
4.08	72,020	0		4.08
4.09	15,901	9		4.09
4.10	3,985	9		4.10
4.11	-42,422	0		4.11
4.12	-635,916	0		4.12
4.13	-20,091	0		4.13
4.14	-96,345	0		4.14
4.15	-5,541	0		4.15
4.16	-57,634	0		4.16
4.17	-24,420	0		4.17
4.18	-25,645	0		4.18
4.19	-16,325	0		4.19
4.20	-315,904	0		4.20
4.21	-53,555	0		4.21
4.22	2,968	14		4.22
4.23	17,525	14		4.23
4.24	182,084	0		4.24
5.00	2,111,345			5.00

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

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

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

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

6.00	HOSPITAL COMPAN		6.00
7.00	COLLECTION AGEN		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 9/29/2015 9:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	23,820	0	23,820	171,400	237	1.00
2.00	30.00	ADULTS & PEDIATRICS	105,130	105,130	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	164,594	164,594	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	2,000	2,000	0	0	0	4.00
5.00	60.00	LABORATORY	91,575	91,575	0	0	0	5.00
6.00	91.00	EMERGENCY	1,835,389	1,835,389	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			2,222,508	2,198,688	23,820		237	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	NURSING ADMINISTRATION	19,530	977	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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			19,530	977	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	13.00	NURSING ADMINISTRATION	0	19,530	4,290	4,290		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	105,130		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	164,594		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	2,000		4.00
5.00	60.00	LABORATORY	0	0	0	91,575		5.00
6.00	91.00	EMERGENCY	0	0	0	1,835,389		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	19,530	4,290	2,202,978		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,297,013	3,297,013				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,739,888		2,739,888			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,243,043	11,560	9,635	4,264,238		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,939,000	431,727	359,815	461,774	8,192,316	5.00
7.00	00700	OPERATION OF PLANT	1,788,256	981,008	817,605	93,964	3,680,833	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190,515	24,472	20,396	0	235,383	8.00
9.00	00900	HOUSEKEEPING	848,157	35,159	29,302	125,855	1,038,473	9.00
10.00	01000	DIETARY	448,733	89,425	74,529	0	612,687	10.00
11.00	01100	CAFETERIA	482,048	43,569	36,312	0	561,929	11.00
13.00	01300	NURSING ADMINISTRATION	1,430,384	48,580	40,488	267,776	1,787,228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	509,487	99,508	82,934	29,014	720,943	14.00
15.00	01500	PHARMACY	798,855	35,273	29,398	141,460	1,004,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	814,626	97,949	81,634	92,156	1,086,365	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,951,003	364,944	304,157	633,725	5,253,829	30.00
31.00	03100	INTENSIVE CARE UNIT	1,716,270	55,753	46,466	298,953	2,117,442	31.00
40.00	04000	SUBPROVIDER - IPF	1,071,890	76,180	63,491	158,198	1,369,759	40.00
43.00	04300	NURSERY	346,520	14,533	12,113	51,424	424,590	43.00
44.00	04400	SKILLED NURSING FACILITY	1,624,466	151,144	125,969	290,465	2,192,044	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,579,159	189,692	150,142	342,778	3,261,771	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	331,504	0	0	49,430	380,934	52.00
53.00	05300	ANESTHESIOLOGY	1,451,531	4,449	3,708	249,019	1,708,707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,210,906	139,407	116,187	248,365	2,714,865	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,475,852	76,315	63,604	227,304	2,843,075	60.00
65.00	06500	RESPIRATORY THERAPY	584,517	28,651	23,879	96,762	733,809	65.00
66.00	06600	PHYSICAL THERAPY	946,847	15,531	12,944	0	975,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	793,936	89,778	74,824	106,514	1,065,052	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	828,624	0	0	0	828,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,531,462	0	0	0	1,531,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,951,775	0	0	0	1,951,775	73.00
74.00	07400	RENAL DIALYSIS	96,243	0	0	0	96,243	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	670,235	58,466	48,727	32,542	809,970	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,685,941	64,693	53,917	239,966	2,044,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,378,686	3,227,766	2,682,176	4,237,444	51,224,933	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	136,222	30,408	25,343	7,008	198,981	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,658	8,049	0	17,707	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	299,039	0	0	19,230	318,269	194.01
194.02	07952	SENIOR CIRCLE	24,478	0	0	556	25,034	194.02
194.03	07953	UNUSED SPACE	0	29,181	24,320	0	53,501	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	51,838,425	3,297,013	2,739,888	4,264,238	51,838,425	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,192,316					5.00
7.00	00700	OPERATION OF PLANT	690,889	4,371,722				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,181	57,127	336,691			8.00
9.00	00900	HOUSEKEEPING	194,920	82,075	0	1,315,468		9.00
10.00	01000	DIETARY	115,001	208,755	0	64,881	1,001,324	10.00
11.00	01100	CAFETERIA	105,474	101,708	0	31,611	0	11.00
13.00	01300	NURSING ADMINISTRATION	335,461	113,405	0	35,246	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	135,320	232,295	4,042	72,197	0	14.00
15.00	01500	PHARMACY	188,635	82,342	0	25,592	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	203,910	228,655	0	71,066	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	986,122	851,937	105,315	264,782	294,446	30.00
31.00	03100	INTENSIVE CARE UNIT	397,442	130,150	35,323	40,451	36,809	31.00
40.00	04000	SUBPROVIDER - IPF	257,102	177,837	16,744	55,272	80,977	40.00
43.00	04300	NURSERY	79,695	33,927	0	10,545	0	43.00
44.00	04400	SKILLED NURSING FACILITY	411,444	352,835	40,481	109,661	242,918	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	612,231	442,822	41,635	137,629	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	71,501	0	0	0	36,809	52.00
53.00	05300	ANESTHESIOLOGY	320,723	10,387	69	3,228	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	509,577	325,437	21,141	101,146	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	533,642	178,153	3,061	55,370	0	60.00
65.00	06500	RESPIRATORY THERAPY	137,735	66,883	1,165	20,787	0	65.00
66.00	06600	PHYSICAL THERAPY	183,067	36,257	0	11,269	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	199,909	209,580	4,952	65,138	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	155,532	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	287,454	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	366,346	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	18,065	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	152,031	136,484	8,783	42,419	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	383,754	151,021	49,848	46,937	44,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,077,163	4,210,072	332,559	1,265,227	736,127	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,349	70,984	0	22,062	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,324	22,545	0	7,007	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	59,739	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	4,699	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	10,042	68,121	4,132	21,172	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	265,197	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,192,316	4,371,722	336,691	1,315,468	1,001,324	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	800,722					11.00
13.00	01300	NURSING ADMINISTRATION	49,793	2,321,133				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,997	0	1,177,794			14.00
15.00	01500	PHARMACY	27,105	0	3,579	1,332,239		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,048	0	3,558	0	1,624,602	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	138,910	537,625	68,216	0	114,327	30.00
31.00	03100	INTENSIVE CARE UNIT	63,373	299,879	33,123	0	49,848	31.00
40.00	04000	SUBPROVIDER - IPF	34,825	158,688	5,726	0	31,851	40.00
43.00	04300	NURSERY	19,606	101,589	210	0	7,507	43.00
44.00	04400	SKILLED NURSING FACILITY	73,760	291,365	37,426	0	17,278	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,204	343,839	169,245	0	328,156	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,857	97,649	30,995	0	7,216	52.00
53.00	05300	ANESTHESIOLOGY	18,607	249,790	19,768	0	116,794	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,708	0	30,337	0	234,054	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	69,816	0	130,971	0	282,228	60.00
65.00	06500	RESPIRATORY THERAPY	24,550	0	18,262	0	50,654	65.00
66.00	06600	PHYSICAL THERAPY	0	0	749	0	25,795	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,134	0	2,248	0	62,364	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	189,613	0	41,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	376,569	0	57,943	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,332,239	44,605	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,296	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	8,026	0	14,768	0	9,043	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	49,627	240,709	41,661	0	141,022	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	794,946	2,321,133	1,177,024	1,332,239	1,624,602	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,777	0	63	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,999	0	691	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	16	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	800,722	2,321,133	1,177,794	1,332,239	1,624,602	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,615,509	0	8,615,509		30.00
31.00	03100	INTENSIVE CARE UNIT	3,203,840	0	3,203,840		31.00
40.00	04000	SUBPROVIDER - IPF	2,188,781	0	2,188,781		40.00
43.00	04300	NURSERY	677,669	0	677,669		43.00
44.00	04400	SKILLED NURSING FACILITY	3,769,212	0	3,769,212		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,412,532	0	5,412,532		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	643,961	0	643,961		52.00
53.00	05300	ANESTHESIOLOGY	2,448,073	0	2,448,073		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,993,265	0	3,993,265		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	4,096,316	0	4,096,316		60.00
65.00	06500	RESPIRATORY THERAPY	1,053,845	0	1,053,845		65.00
66.00	06600	PHYSICAL THERAPY	1,232,459	0	1,232,459		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,631,377	0	1,631,377		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,215,390	0	1,215,390		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,253,428	0	2,253,428		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,694,965	0	3,694,965		73.00
74.00	07400	RENAL DIALYSIS	116,604	0	116,604		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	1,181,524	0	1,181,524		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	3,193,264	0	3,193,264		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,622,014	0	50,622,014		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	332,216	0	332,216		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	50,583	0	50,583		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	381,698	0	381,698		194.01
194.02	07952	SENIOR CIRCLE	29,749	0	29,749		194.02
194.03	07953	UNUSED SPACE	156,968	0	156,968		194.03
194.04	07954	GUEST MEALS	265,197	0	265,197		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	51,838,425	0	51,838,425		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,560	9,635	21,195	21,195	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	431,727	359,815	791,542	2,295	5.00
7.00	00700	OPERATION OF PLANT	0	981,008	817,605	1,798,613	467	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,472	20,396	44,868	0	8.00
9.00	00900	HOUSEKEEPING	0	35,159	29,302	64,461	625	9.00
10.00	01000	DIETARY	0	89,425	74,529	163,954	0	10.00
11.00	01100	CAFETERIA	0	43,569	36,312	79,881	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	48,580	40,488	89,068	1,331	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	99,508	82,934	182,442	144	14.00
15.00	01500	PHARMACY	0	35,273	29,398	64,671	703	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	97,949	81,634	179,583	458	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	364,944	304,157	669,101	3,154	30.00
31.00	03100	INTENSIVE CARE UNIT	0	55,753	46,466	102,219	1,486	31.00
40.00	04000	SUBPROVIDER - IPF	0	76,180	63,491	139,671	786	40.00
43.00	04300	NURSERY	0	14,533	12,113	26,646	256	43.00
44.00	04400	SKILLED NURSING FACILITY	0	151,144	125,969	277,113	1,443	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	189,692	150,142	339,834	1,703	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	246	52.00
53.00	05300	ANESTHESIOLOGY	0	4,449	3,708	8,157	1,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	139,407	116,187	255,594	1,234	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	76,315	63,604	139,919	1,129	60.00
65.00	06500	RESPIRATORY THERAPY	0	28,651	23,879	52,530	481	65.00
66.00	06600	PHYSICAL THERAPY	0	15,531	12,944	28,475	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	89,778	74,824	164,602	529	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	58,466	48,727	107,193	162	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	64,693	53,917	118,610	1,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,227,766	2,682,176	5,909,942	21,061	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,408	25,343	55,751	35	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,658	8,049	17,707	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	96	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	3	194.02
194.03	07953	UNUSED SPACE	0	29,181	24,320	53,501	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,297,013	2,739,888	6,036,901	21,195	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	793,837					5.00
7.00	00700	OPERATION OF PLANT	66,947	1,866,027				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,281	24,384	73,533			8.00
9.00	00900	HOUSEKEEPING	18,888	35,033	0	119,007		9.00
10.00	01000	DIETARY	11,144	89,105	0	5,870	270,073	10.00
11.00	01100	CAFETERIA	10,220	43,413	0	2,860	0	11.00
13.00	01300	NURSING ADMINISTRATION	32,506	48,406	0	3,189	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,113	99,153	883	6,532	0	14.00
15.00	01500	PHARMACY	18,279	35,147	0	2,315	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,759	97,599	0	6,429	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,558	363,642	23,002	23,954	79,416	30.00
31.00	03100	INTENSIVE CARE UNIT	38,512	55,553	7,715	3,659	9,928	31.00
40.00	04000	SUBPROVIDER - IPF	24,913	75,908	3,657	5,000	21,841	40.00
43.00	04300	NURSERY	7,722	14,481	0	954	0	43.00
44.00	04400	SKILLED NURSING FACILITY	39,869	150,604	8,841	9,921	65,519	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,325	189,014	9,093	12,451	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,928	0	0	0	9,928	52.00
53.00	05300	ANESTHESIOLOGY	31,078	4,434	15	292	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,378	138,909	4,617	9,150	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	51,710	76,043	668	5,009	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,347	28,548	254	1,881	0	65.00
66.00	06600	PHYSICAL THERAPY	17,739	15,476	0	1,019	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,371	89,457	1,081	5,893	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,071	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,854	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,499	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,750	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	14,732	58,257	1,918	3,838	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	37,186	64,462	10,887	4,246	11,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	782,679	1,797,028	72,631	114,462	198,545	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,619	30,299	0	1,996	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	322	9,623	0	634	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	5,789	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	455	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	973	29,077	902	1,915	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	71,528	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	793,837	1,866,027	73,533	119,007	270,073	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	136,374					11.00
13.00	01300	NURSING ADMINISTRATION	8,481	182,981				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,214	0	304,481			14.00
15.00	01500	PHARMACY	4,616	0	925	126,656		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,288	0	920	0	310,036	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,658	42,381	17,635	0	21,814	30.00
31.00	03100	INTENSIVE CARE UNIT	10,793	23,640	8,563	0	9,511	31.00
40.00	04000	SUBPROVIDER - IPF	5,931	12,510	1,480	0	6,077	40.00
43.00	04300	NURSERY	3,339	8,009	54	0	1,432	43.00
44.00	04400	SKILLED NURSING FACILITY	12,562	22,969	9,675	0	3,297	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,808	27,106	43,753	0	62,668	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,212	7,698	8,013	0	1,377	52.00
53.00	05300	ANESTHESIOLOGY	3,169	19,692	5,110	0	22,285	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,658	0	7,843	0	44,659	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,891	0	33,858	0	53,850	60.00
65.00	06500	RESPIRATORY THERAPY	4,181	0	4,721	0	9,665	65.00
66.00	06600	PHYSICAL THERAPY	0	0	194	0	4,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,770	0	581	0	11,899	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	49,018	0	7,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	97,351	0	11,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	126,656	8,511	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	438	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	1,367	0	3,818	0	1,726	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	8,452	18,976	10,770	0	26,908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	135,390	182,981	304,282	126,656	310,036	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	473	0	16	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	511	0	179	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	4	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	136,374	182,981	304,481	126,656	310,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,363,315	0	1,363,315		30.00
31.00	03100	INTENSIVE CARE UNIT	271,579	0	271,579		31.00
40.00	04000	SUBPROVIDER - IPF	297,774	0	297,774		40.00
43.00	04300	NURSERY	62,893	0	62,893		43.00
44.00	04400	SKILLED NURSING FACILITY	601,813	0	601,813		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	757,755	0	757,755		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,402	0	37,402		52.00
53.00	05300	ANESTHESIOLOGY	95,469	0	95,469		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,042	0	521,042		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	374,077	0	374,077		60.00
65.00	06500	RESPIRATORY THERAPY	115,608	0	115,608		65.00
66.00	06600	PHYSICAL THERAPY	67,825	0	67,825		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	297,183	0	297,183		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,030	0	72,030		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,261	0	136,261		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,666	0	170,666		73.00
74.00	07400	RENAL DIALYSIS	2,188	0	2,188		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	193,011	0	193,011		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	313,602	0	313,602		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,751,493	0	5,751,493		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	92,189	0	92,189		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,286	0	28,286		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	6,575	0	6,575		194.01
194.02	07952	SENIOR CIRCLE	462	0	462		194.02
194.03	07953	UNUSED SPACE	86,368	0	86,368		194.03
194.04	07954	GUEST MEALS	71,528	0	71,528		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	6,036,901	0	6,036,901		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	317,149					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		316,231				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,112	1,112	19,619,709			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,529	41,529	2,124,615	-8,192,316	43,646,109	5.00
7.00	00700	OPERATION OF PLANT	94,366	94,366	432,328	0	3,680,833	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	2,354	0	0	235,383	8.00
9.00	00900	HOUSEKEEPING	3,382	3,382	579,058	0	1,038,473	9.00
10.00	01000	DIETARY	8,602	8,602	0	0	612,687	10.00
11.00	01100	CAFETERIA	4,191	4,191	0	0	561,929	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	4,673	1,232,030	0	1,787,228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,572	9,572	133,492	0	720,943	14.00
15.00	01500	PHARMACY	3,393	3,393	650,853	0	1,004,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	9,422	424,008	0	1,086,365	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,105	35,105	2,915,782	0	5,253,829	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	5,363	1,375,479	0	2,117,442	31.00
40.00	04000	SUBPROVIDER - IPF	7,328	7,328	727,866	0	1,369,759	40.00
43.00	04300	NURSERY	1,398	1,398	236,603	0	424,590	43.00
44.00	04400	SKILLED NURSING FACILITY	14,539	14,539	1,336,425	0	2,192,044	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,247	17,329	1,577,114	0	3,261,771	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	227,427	0	380,934	52.00
53.00	05300	ANESTHESIOLOGY	428	428	1,145,733	0	1,708,707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,410	13,410	1,142,723	0	2,714,865	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,341	7,341	1,045,820	0	2,843,075	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	2,756	445,201	0	733,809	65.00
66.00	06600	PHYSICAL THERAPY	1,494	1,494	0	0	975,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,636	8,636	490,067	0	1,065,052	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	828,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,531,462	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,951,775	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	96,243	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	5,624	5,624	149,726	0	809,970	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	6,223	6,223	1,104,080	0	2,044,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,488	309,570	19,496,430	-8,192,316	43,032,617	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	2,925	32,245	0	198,981	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	929	0	0	17,707	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	88,478	0	318,269	194.01
194.02	07952	SENIOR CIRCLE	0	0	2,556	0	25,034	194.02
194.03	07953	UNUSED SPACE	2,807	2,807	0	0	53,501	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,297,013	2,739,888	4,264,238		8,192,316	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.395786	8.664198	0.217345		0.187699	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			21,195		793,837	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001080		0.018188	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	180,142					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	427,682				8.00
9.00	00900	HOUSEKEEPING	3,382	0	174,406			9.00
10.00	01000	DIETARY	8,602	0	8,602	69,259		10.00
11.00	01100	CAFETERIA	4,191	0	4,191	0	28,833	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	0	4,673	0	1,793	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,572	5,134	9,572	0	468	14.00
15.00	01500	PHARMACY	3,393	0	3,393	0	976	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	0	9,422	0	1,118	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,105	133,776	35,105	20,366	5,002	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	44,869	5,363	2,546	2,282	31.00
40.00	04000	SUBPROVIDER - IPF	7,328	21,269	7,328	5,601	1,254	40.00
43.00	04300	NURSERY	1,398	0	1,398	0	706	43.00
44.00	04400	SKILLED NURSING FACILITY	14,539	51,421	14,539	16,802	2,656	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,247	52,887	18,247	0	2,708	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,546	679	52.00
53.00	05300	ANESTHESIOLOGY	428	88	428	0	670	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,410	26,855	13,410	0	2,042	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,341	3,888	7,341	0	2,514	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	1,480	2,756	0	884	65.00
66.00	06600	PHYSICAL THERAPY	1,494	0	1,494	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,636	6,290	8,636	0	797	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	5,624	11,156	5,624	0	289	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	6,223	63,320	6,223	3,055	1,787	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	173,481	422,433	167,745	50,916	28,625	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	0	2,925	0	100	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	0	929	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	108	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	2,807	5,249	2,807	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	18,343	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,371,722	336,691	1,315,468	1,001,324	800,722	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.268200	0.787246	7.542562	14.457673	27.771026	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,866,027	73,533	119,007	270,073	136,374	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/29/2015 9:22 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	10.358645	0.171934	0.682356	3.899464	4.729789	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	10,646,509					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,041,361				14.00
15.00	01500	PHARMACY	0	12,279	1,952,290			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,209	0	360,896,620		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,465,953	234,068	0	25,394,821		30.00
31.00	03100	INTENSIVE CARE UNIT	1,375,479	113,656	0	11,072,440		31.00
40.00	04000	SUBPROVIDER - IPF	727,866	19,649	0	7,074,779		40.00
43.00	04300	NURSERY	465,966	722	0	1,667,457		43.00
44.00	04400	SKILLED NURSING FACILITY	1,336,425	128,419	0	3,837,817		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,577,114	580,730	0	72,925,268		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	447,893	106,354	0	1,602,784		52.00
53.00	05300	ANESTHESIOLOGY	1,145,733	67,829	0	25,942,617		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	104,094	0	51,988,986		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	449,401	0	62,689,571		60.00
65.00	06500	RESPIRATORY THERAPY	0	62,664	0	11,251,543		65.00
66.00	06600	PHYSICAL THERAPY	0	2,570	0	5,729,708		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,714	0	13,852,491		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	650,619	0	9,245,006		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,292,116	0	12,870,465		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,952,290	9,907,802		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	509,919		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		76.02
76.03	03950	WOUND CARE	0	50,674	0	2,008,736		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	1,104,080	142,951	0	31,324,410		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.00	09900	CMHC	0	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,646,509	4,038,718	1,952,290	360,896,620		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	217	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	2,370	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	56	0	0		194.02
194.03	07953	UNUSED SPACE	0	0	0	0		194.03
194.04	07954	GUEST MEALS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,321,133	1,177,794	1,332,239	1,624,602		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.218018	0.291435	0.682398	0.004502		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	182,981	304,481	126,656	310,036		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/29/2015 9:22 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017187	0.075341	0.064876	0.000859		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,615,509		8,615,509	0	8,615,509	30.00
31.00	03100	INTENSIVE CARE UNIT	3,203,840		3,203,840	0	3,203,840	31.00
40.00	04000	SUBPROVIDER - IPF	2,188,781		2,188,781	0	2,188,781	40.00
43.00	04300	NURSERY	677,669		677,669	0	677,669	43.00
44.00	04400	SKILLED NURSING FACILITY	3,769,212		3,769,212	0	3,769,212	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,412,532		5,412,532	0	5,412,532	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	643,961		643,961	0	643,961	52.00
53.00	05300	ANESTHESIOLOGY	2,448,073		2,448,073	0	2,448,073	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,993,265		3,993,265	0	3,993,265	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	4,096,316		4,096,316	0	4,096,316	60.00
65.00	06500	RESPIRATORY THERAPY	1,053,845	0	1,053,845	0	1,053,845	65.00
66.00	06600	PHYSICAL THERAPY	1,232,459	0	1,232,459	0	1,232,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,631,377		1,631,377	0	1,631,377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,215,390		1,215,390	0	1,215,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,253,428		2,253,428	0	2,253,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,694,965		3,694,965	0	3,694,965	73.00
74.00	07400	RENAL DIALYSIS	116,604		116,604	0	116,604	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03950	WOUND CARE	1,181,524		1,181,524	0	1,181,524	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,193,264		3,193,264	0	3,193,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	820,747		820,747		820,747	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	51,442,761	0	51,442,761	0	51,442,761	200.00
201.00		Less Observation Beds	820,747		820,747		820,747	201.00
202.00		Total (see instructions)	50,622,014	0	50,622,014	0	50,622,014	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,017,741		22,017,741			30.00
31.00	03100	INTENSIVE CARE UNIT	11,072,440		11,072,440			31.00
40.00	04000	SUBPROVIDER - IPF	7,074,779		7,074,779			40.00
43.00	04300	NURSERY	1,667,457		1,667,457			43.00
44.00	04400	SKILLED NURSING FACILITY	3,837,817		3,837,817			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,137,924	47,787,344	72,925,268	0.074220	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,428,679	174,105	1,602,784	0.401777	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,755,461	16,187,156	25,942,617	0.094365	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,711,113	43,277,873	51,988,986	0.076810	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	18,065,593	44,623,978	62,689,571	0.065343	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,024,110	5,227,433	11,251,543	0.093662	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,584,434	145,274	5,729,708	0.215100	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,541,165	10,311,326	13,852,491	0.117768	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,997,225	2,247,781	9,245,006	0.131464	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,394,565	5,475,900	12,870,465	0.175085	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,393,537	3,514,265	9,907,802	0.372935	0.000000	73.00
74.00	07400	RENAL DIALYSIS	495,456	14,463	509,919	0.228672	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03950	WOUND CARE	3,582	2,005,154	2,008,736	0.588193	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	5,034,776	26,289,634	31,324,410	0.101942	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	928,943	2,448,137	3,377,080	0.243035	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	151,166,797	209,729,823	360,896,620			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	151,166,797	209,729,823	360,896,620			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.074220		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.401777		52.00
53.00	05300	ANESTHESIOLOGY	0.094365		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076810		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.065343		60.00
65.00	06500	RESPIRATORY THERAPY	0.093662		65.00
66.00	06600	PHYSICAL THERAPY	0.215100		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.117768		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131464		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.175085		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372935		73.00
74.00	07400	RENAL DIALYSIS	0.228672		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.02
76.03	03950	WOUND CARE	0.588193		76.03
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100	EMERGENCY	0.101942		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.243035		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,615,509		8,615,509	0	8,615,509	30.00
31.00	03100	INTENSIVE CARE UNIT	3,203,840		3,203,840	0	3,203,840	31.00
40.00	04000	SUBPROVIDER - IPF	2,188,781		2,188,781	0	2,188,781	40.00
43.00	04300	NURSERY	677,669		677,669	0	677,669	43.00
44.00	04400	SKILLED NURSING FACILITY	3,769,212		3,769,212	0	3,769,212	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,412,532		5,412,532	0	5,412,532	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	643,961		643,961	0	643,961	52.00
53.00	05300	ANESTHESIOLOGY	2,448,073		2,448,073	0	2,448,073	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,993,265		3,993,265	0	3,993,265	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	4,096,316		4,096,316	0	4,096,316	60.00
65.00	06500	RESPIRATORY THERAPY	1,053,845	0	1,053,845	0	1,053,845	65.00
66.00	06600	PHYSICAL THERAPY	1,232,459	0	1,232,459	0	1,232,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,631,377		1,631,377	0	1,631,377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,215,390		1,215,390	0	1,215,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,253,428		2,253,428	0	2,253,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,694,965		3,694,965	0	3,694,965	73.00
74.00	07400	RENAL DIALYSIS	116,604		116,604	0	116,604	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03950	WOUND CARE	1,181,524		1,181,524	0	1,181,524	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	3,193,264		3,193,264	0	3,193,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	820,747		820,747		820,747	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	51,442,761	0	51,442,761	0	51,442,761	200.00
201.00		Less Observation Beds	820,747		820,747		820,747	201.00
202.00		Total (see instructions)	50,622,014	0	50,622,014	0	50,622,014	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,017,741		22,017,741			30.00
31.00	03100	INTENSIVE CARE UNIT	11,072,440		11,072,440			31.00
40.00	04000	SUBPROVIDER - IPF	7,074,779		7,074,779			40.00
43.00	04300	NURSERY	1,667,457		1,667,457			43.00
44.00	04400	SKILLED NURSING FACILITY	3,837,817		3,837,817			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,137,924	47,787,344	72,925,268	0.074220	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,428,679	174,105	1,602,784	0.401777	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	9,755,461	16,187,156	25,942,617	0.094365	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,711,113	43,277,873	51,988,986	0.076810	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	18,065,593	44,623,978	62,689,571	0.065343	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,024,110	5,227,433	11,251,543	0.093662	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,584,434	145,274	5,729,708	0.215100	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	3,541,165	10,311,326	13,852,491	0.117768	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,997,225	2,247,781	9,245,006	0.131464	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,394,565	5,475,900	12,870,465	0.175085	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,393,537	3,514,265	9,907,802	0.372935	0.000000	73.00
74.00	07400	RENAL DIALYSIS	495,456	14,463	509,919	0.228672	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03950	WOUND CARE	3,582	2,005,154	2,008,736	0.588193	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	5,034,776	26,289,634	31,324,410	0.101942	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	928,943	2,448,137	3,377,080	0.243035	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	151,166,797	209,729,823	360,896,620			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	151,166,797	209,729,823	360,896,620			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.074220	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.401777	52.00
53.00	05300	ANESTHESIOLOGY	0.094365	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076810	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.065343	60.00
65.00	06500	RESPIRATORY THERAPY	0.093662	65.00
66.00	06600	PHYSICAL THERAPY	0.215100	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117768	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131464	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.175085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372935	73.00
74.00	07400	RENAL DIALYSIS	0.228672	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	76.00
76.01	03610	SLEEP LAB	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.02
76.03	03950	WOUND CARE	0.588193	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
91.00	09100	EMERGENCY	0.101942	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.243035	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
99.00	09900	CMHC		99.00
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part II Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,412,532	757,755	4,654,777	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	643,961	37,402	606,559	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,448,073	95,469	2,352,604	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,993,265	521,042	3,472,223	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,096,316	374,077	3,722,239	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,053,845	115,608	938,237	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,232,459	67,825	1,164,634	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,631,377	297,183	1,334,194	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,215,390	72,030	1,143,360	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,253,428	136,261	2,117,167	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,694,965	170,666	3,524,299	0	0	73.00
74.00	07400	RENAL DIALYSIS	116,604	2,188	114,416	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	1,181,524	193,011	988,513	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	3,193,264	313,602	2,879,662	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	820,747	129,875	690,872	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	32,987,750	3,283,994	29,703,756	0	0	200.00
201.00		Less Observation Beds	820,747	129,875	690,872	0	0	201.00
202.00		Total (line 200 minus line 201)	32,167,003	3,154,119	29,012,884	0	0	202.00

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

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part II Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,412,532	72,925,268	0.074220		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	643,961	1,602,784	0.401777		52.00
53.00	05300	ANESTHESIOLOGY	2,448,073	25,942,617	0.094365		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,993,265	51,988,986	0.076810		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	4,096,316	62,689,571	0.065343		60.00
65.00	06500	RESPIRATORY THERAPY	1,053,845	11,251,543	0.093662		65.00
66.00	06600	PHYSICAL THERAPY	1,232,459	5,729,708	0.215100		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,631,377	13,852,491	0.117768		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,215,390	9,245,006	0.131464		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,253,428	12,870,465	0.175085		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,694,965	9,907,802	0.372935		73.00
74.00	07400	RENAL DIALYSIS	116,604	509,919	0.228672		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	0	0	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000		76.02
76.03	03950	WOUND CARE	1,181,524	2,008,736	0.588193		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
91.00	09100	EMERGENCY	3,193,264	31,324,410	0.101942		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	820,747	3,377,080	0.243035		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
99.00	09900	CMHC	0	0	0.000000		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
200.00		Subtotal (sum of lines 50 thru 199)	32,987,750	315,226,386			200.00
201.00		Less Observation Beds	820,747	0			201.00
202.00		Total (line 200 minus line 201)	32,167,003	315,226,386			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part I Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,363,315	0	1,363,315	9,080	150.14	30.00
31.00	INTENSIVE CARE UNIT	271,579		271,579	2,002	135.65	31.00
40.00	SUBPROVIDER - IPF	297,774	0	297,774	2,255	132.05	40.00
43.00	NURSERY	62,893		62,893	834	75.41	43.00
44.00	SKILLED NURSING FACILITY	601,813		601,813	5,200	115.73	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	2,597,374		2,597,374	19,371		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	4,581	687,791	30.00
31.00	INTENSIVE CARE UNIT	1,269	172,140	31.00
40.00	SUBPROVIDER - IPF	1,675	221,184	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	4,022	465,466	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	11,547	1,546,581	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part II Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	757,755	72,925,268	0.010391	11,607,867	120,617	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,402	1,602,784	0.023336	5,384	126	52.00
53.00	05300	ANESTHESIOLOGY	95,469	25,942,617	0.003680	4,389,838	16,155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,042	51,988,986	0.010022	5,198,873	52,103	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	374,077	62,689,571	0.005967	8,716,717	52,013	60.00
65.00	06500	RESPIRATORY THERAPY	115,608	11,251,543	0.010275	2,678,788	27,525	65.00
66.00	06600	PHYSICAL THERAPY	67,825	5,729,708	0.011837	1,228,540	14,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	297,183	13,852,491	0.021453	2,045,930	43,891	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,030	9,245,006	0.007791	3,377,704	26,316	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,261	12,870,465	0.010587	3,780,459	40,024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,666	9,907,802	0.017225	2,654,287	45,720	73.00
74.00	07400	RENAL DIALYSIS	2,188	509,919	0.004291	110,237	473	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	193,011	2,008,736	0.096086	3,582	344	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	313,602	31,324,410	0.010011	2,947,669	29,509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	129,875	3,377,080	0.038458	384,959	14,805	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,283,994	315,226,386		49,130,834	484,163	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part III Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,080	0.00	4,581	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,002	0.00	1,269	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,255	0.00	1,675	0		40.00
43.00	04300	NURSERY	834	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,200	0.00	4,022	0		44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	19,371		11,547	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	72,925,268	0.000000	0.000000	11,607,867	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,602,784	0.000000	0.000000	5,384	52.00
53.00	05300	ANESTHESIOLOGY	0	25,942,617	0.000000	0.000000	4,389,838	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,988,986	0.000000	0.000000	5,198,873	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	62,689,571	0.000000	0.000000	8,716,717	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,251,543	0.000000	0.000000	2,678,788	65.00
66.00	06600	PHYSICAL THERAPY	0	5,729,708	0.000000	0.000000	1,228,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,852,491	0.000000	0.000000	2,045,930	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,245,006	0.000000	0.000000	3,377,704	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,870,465	0.000000	0.000000	3,780,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,907,802	0.000000	0.000000	2,654,287	73.00
74.00	07400	RENAL DIALYSIS	0	509,919	0.000000	0.000000	110,237	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,008,736	0.000000	0.000000	3,582	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	31,324,410	0.000000	0.000000	2,947,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,377,080	0.000000	0.000000	384,959	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	315,226,386			49,130,834	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	13,413,099	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	4,076,772	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,204,298	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	4,196,549	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,016,111	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,620,678	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	506,536	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,476,329	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,471,699	0		73.00
74.00	07400	RENAL DIALYSIS	0	1,426	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	980,710	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	4,696,653	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	650,271	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	51,311,131	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.074220	13,413,099	0	0	995,520	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.401777	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.094365	4,076,772	0	0	384,705	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076810	12,204,298	0	0	937,412	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.065343	4,196,549	0	0	274,215	60.00
65.00	06500	RESPIRATORY THERAPY	0.093662	2,016,111	0	0	188,833	65.00
66.00	06600	PHYSICAL THERAPY	0.215100	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117768	4,620,678	0	0	544,168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131464	506,536	0	0	66,591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.175085	2,476,329	0	0	433,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372935	1,471,699	0	2,030	548,848	73.00
74.00	07400	RENAL DIALYSIS	0.228672	1,426	0	0	326	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03950	WOUND CARE	0.588193	980,710	0	0	576,847	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.101942	4,696,653	0	0	478,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.243035	650,271	0	0	158,039	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		51,311,131	0	2,030	5,587,858	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		51,311,131	0	2,030	5,587,858	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	757		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	757		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	757		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part II Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	757,755	72,925,268	0.010391	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,402	1,602,784	0.023336	0	0	52.00
53.00	05300	ANESTHESIOLOGY	95,469	25,942,617	0.003680	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,042	51,988,986	0.010022	294,576	2,952	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	374,077	62,689,571	0.005967	831,984	4,964	60.00
65.00	06500	RESPIRATORY THERAPY	115,608	11,251,543	0.010275	73,584	756	65.00
66.00	06600	PHYSICAL THERAPY	67,825	5,729,708	0.011837	232,518	2,752	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	297,183	13,852,491	0.021453	62,793	1,347	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,030	9,245,006	0.007791	682	5	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,261	12,870,465	0.010587	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,666	9,907,802	0.017225	340,663	5,868	73.00
74.00	07400	RENAL DIALYSIS	2,188	509,919	0.004291	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	193,011	2,008,736	0.096086	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	313,602	31,324,410	0.010011	173,296	1,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,377,080	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,154,119	315,226,386		2,010,096	20,379	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	72,925,268	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,602,784	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	25,942,617	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,988,986	0.000000	0.000000	294,576	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	62,689,571	0.000000	0.000000	831,984	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,251,543	0.000000	0.000000	73,584	65.00
66.00	06600	PHYSICAL THERAPY	0	5,729,708	0.000000	0.000000	232,518	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,852,491	0.000000	0.000000	62,793	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,245,006	0.000000	0.000000	682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,870,465	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,907,802	0.000000	0.000000	340,663	73.00
74.00	07400	RENAL DIALYSIS	0	509,919	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,008,736	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	31,324,410	0.000000	0.000000	173,296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,377,080	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	315,226,386			2,010,096	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	72,925,268	0.000000	0.000000	1,466	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,602,784	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	25,942,617	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,988,986	0.000000	0.000000	208,822	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	62,689,571	0.000000	0.000000	1,428,562	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,251,543	0.000000	0.000000	1,270,210	65.00
66.00	06600	PHYSICAL THERAPY	0	5,729,708	0.000000	0.000000	2,412,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,852,491	0.000000	0.000000	114,822	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,245,006	0.000000	0.000000	1,143,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,870,465	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,907,802	0.000000	0.000000	1,104,082	73.00
74.00	07400	RENAL DIALYSIS	0	509,919	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,008,736	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	31,324,410	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,377,080	0.000000	0.000000	1,692	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	315,226,386			7,686,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part I Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,363,315	0	1,363,315	9,080	150.14	30.00
31.00	INTENSIVE CARE UNIT	271,579		271,579	2,002	135.65	31.00
40.00	SUBPROVIDER - IPF	297,774	0	297,774	2,255	132.05	40.00
43.00	NURSERY	62,893		62,893	834	75.41	43.00
44.00	SKILLED NURSING FACILITY	601,813		601,813	5,200	115.73	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	2,597,374		2,597,374	19,371		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	865	129,871	30.00
31.00	INTENSIVE CARE UNIT	153	20,754	31.00
40.00	SUBPROVIDER - IPF	7	924	40.00
43.00	NURSERY	419	31,597	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	1,444	183,146	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part II Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	757,755	72,925,268	0.010391	3,852,607	40,032	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,402	1,602,784	0.023336	972,850	22,702	52.00
53.00	05300	ANESTHESIOLOGY	95,469	25,942,617	0.003680	1,619,278	5,959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	521,042	51,988,986	0.010022	640,890	6,423	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	374,077	62,689,571	0.005967	1,743,939	10,406	60.00
65.00	06500	RESPIRATORY THERAPY	115,608	11,251,543	0.010275	276,352	2,840	65.00
66.00	06600	PHYSICAL THERAPY	67,825	5,729,708	0.011837	182,775	2,164	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	297,183	13,852,491	0.021453	130,481	2,799	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,030	9,245,006	0.007791	1,102,808	8,592	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,261	12,870,465	0.010587	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	170,666	9,907,802	0.017225	524,015	9,026	73.00
74.00	07400	RENAL DIALYSIS	2,188	509,919	0.004291	9,155	39	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	193,011	2,008,736	0.096086	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	313,602	31,324,410	0.010011	126,024	1,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	129,875	3,377,080	0.038458	84,210	3,239	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,283,994	315,226,386		11,265,384	115,483	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part III Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,080	0.00	865	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,002	0.00	153	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,255	0.00	7	0		40.00
43.00	04300	NURSERY	834	0.00	419	0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,200	0.00	0	0		44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	19,371		1,444	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	72,925,268	0.000000	0.000000	3,852,607	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,602,784	0.000000	0.000000	972,850	52.00
53.00	05300	ANESTHESIOLOGY	0	25,942,617	0.000000	0.000000	1,619,278	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,988,986	0.000000	0.000000	640,890	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	62,689,571	0.000000	0.000000	1,743,939	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,251,543	0.000000	0.000000	276,352	65.00
66.00	06600	PHYSICAL THERAPY	0	5,729,708	0.000000	0.000000	182,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,852,491	0.000000	0.000000	130,481	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,245,006	0.000000	0.000000	1,102,808	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,870,465	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,907,802	0.000000	0.000000	524,015	73.00
74.00	07400	RENAL DIALYSIS	0	509,919	0.000000	0.000000	9,155	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,008,736	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	31,324,410	0.000000	0.000000	126,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,377,080	0.000000	0.000000	84,210	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	315,226,386			11,265,384	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,080	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,080	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.	126	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,089	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)	4,581	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,615,509	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,615,509	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	22,017,741	28.00
29.00	Private room charges (excluding swing-bed charges)	357,565	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	21,660,176	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.391298	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,837.82	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	2,677.73	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	160.09	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	62.64	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	7,893	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,607,616	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)	948.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,346,636	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)	4,346,636	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,203,840	2,002	1,600.32	1,269	2,030,806	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	5,520,142	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,897,584	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)	859,931	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	484,163	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,344,094	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	10,553,490	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)	865	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	948.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	820,747	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

	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	1,363,315	8,615,509	0.158240	820,747	129,875	90.00
91.00	Nursing School cost	0	8,615,509	0.000000	820,747	0	91.00
92.00	Allied health cost	0	8,615,509	0.000000	820,747	0	92.00
93.00	All other Medical Education	0	8,615,509	0.000000	820,747	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2014 To 04/30/2015	Worksheet D-1 Date/Time Prepared: 9/29/2015 9:22 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,255	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,255	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,255	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,675	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,188,781	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,188,781	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,188,781	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)	970.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,625,805	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,625,805	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	286,093	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,911,898	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)	221,184	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	20,379	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	241,563	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,670,335	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)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1

Component CCN: 14S040 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Subprovider - IPF | PPS

	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	297,774	2,188,781	0.136046	0	0	90.00
91.00	Nursing School cost	0	2,188,781	0.000000	0	0	91.00
92.00	Allied health cost	0	2,188,781	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,188,781	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 145690	Period: From 05/01/2014 To 04/30/2015	Worksheet D-1 Date/Time Prepared: 9/29/2015 9:22 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,200	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,200	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)	5,200	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)	4,022	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,769,212	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,769,212	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,769,212	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1

Component CCN: 145690 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	3,769,212	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	724.85	71.00
72.00	Program routine service cost (line 9 x line 71)	2,915,347	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,915,347	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,915,347	83.00
84.00	Program inpatient ancillary services (see instructions)	1,323,517	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	4,238,864	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1

Component CCN: 145690 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Skilled Nursing Facility | PPS

	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,080	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,080	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)	8,215	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)	865	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)	834	15.00
16.00	Nursery days (title V or XIX only)	419	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8,615,509	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,615,509	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,615,509	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)	948.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	820,747	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)	820,747	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	677,669	834	812.55	419	340,458	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,203,840	2,002	1,600.32	153	244,849	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,449,168	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,855,222	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)	182,222	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	115,483	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	297,705	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,557,517	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)	865	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	948.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	820,747	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

	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	1,363,315	8,615,509	0.158240	820,747	129,875	90.00
91.00	Nursing School cost	0	8,615,509	0.000000	820,747	0	91.00
92.00	Allied health cost	0	8,615,509	0.000000	820,747	0	92.00
93.00	All other Medical Education	0	8,615,509	0.000000	820,747	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		11,612,078		30.00
31.00	03100	INTENSIVE CARE UNIT		7,012,032		31.00
40.00	04000	SUBPROVIDER - IPF		132,064		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.074220	11,607,867	861,536	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.401777	5,384	2,163	52.00
53.00	05300	ANESTHESIOLOGY	0.094365	4,389,838	414,247	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076810	5,198,873	399,325	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.065343	8,716,717	569,576	60.00
65.00	06500	RESPIRATORY THERAPY	0.093662	2,678,788	250,901	65.00
66.00	06600	PHYSICAL THERAPY	0.215100	1,228,540	264,259	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117768	2,045,930	240,945	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131464	3,377,704	444,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.175085	3,780,459	661,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372935	2,654,287	989,877	73.00
74.00	07400	RENAL DIALYSIS	0.228672	110,237	25,208	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.588193	3,582	2,107	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.101942	2,947,669	300,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.243035	384,959	93,559	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		49,130,834	5,520,142	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		49,130,834		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		10,755		31.00
40.00	04000	SUBPROVIDER - IPF		3,809,354		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.074220	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.401777	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.094365	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076810	294,576	22,626	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.065343	831,984	54,364	60.00
65.00	06500	RESPIRATORY THERAPY	0.093662	73,584	6,892	65.00
66.00	06600	PHYSICAL THERAPY	0.215100	232,518	50,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117768	62,793	7,395	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131464	682	90	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.175085	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372935	340,663	127,045	73.00
74.00	07400	RENAL DIALYSIS	0.228672	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.588193	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.101942	173,296	17,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.243035	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,010,096	286,093	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,010,096		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.074220	1,466	109	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.401777	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.094365	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076810	208,822	16,040	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.065343	1,428,562	93,347	60.00
65.00	06500	RESPIRATORY THERAPY	0.093662	1,270,210	118,970	65.00
66.00	06600	PHYSICAL THERAPY	0.215100	2,412,774	518,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117768	114,822	13,522	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131464	1,143,878	150,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.175085	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372935	1,104,082	411,751	73.00
74.00	07400	RENAL DIALYSIS	0.228672	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.588193	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.101942	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.243035	1,692	411	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		7,686,308	1,323,517	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		7,686,308		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/29/2015 9:22 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,367,633		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.074220	3,852,607	285,940	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.401777	972,850	390,869	52.00
53.00	05300	ANESTHESIOLOGY	0.094365	1,619,278	152,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.076810	640,890	49,227	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.065343	1,743,939	113,954	60.00
65.00	06500	RESPIRATORY THERAPY	0.093662	276,352	25,884	65.00
66.00	06600	PHYSICAL THERAPY	0.215100	182,775	39,315	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.117768	130,481	15,366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.131464	1,102,808	144,980	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.175085	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.372935	524,015	195,424	73.00
74.00	07400	RENAL DIALYSIS	0.228672	9,155	2,093	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.588193	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100	EMERGENCY	0.101942	126,024	12,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.243035	84,210	20,466	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		11,265,384	1,449,168	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		11,265,384		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,245,306			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,631,532			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		142,980			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		93.63			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part A Date/Time Prepared: 9/29/2015 9:22 am

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.59			30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.04			31.00
32.00	Sum of lines 30 and 31		21.63			32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.06			33.00
34.00	Disproportionate share adjustment (see instructions)		139,027			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)		9,046,380,143		0	35.00
35.01	Factor 3 (see instructions)		0.000091326		0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		826,174		515,438	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		346,314		299,378	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		645,692			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		8,804,537			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		8,966,558			48.00
49.00	Total payment for inpatient operating costs (see instructions)		8,926,053			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		653,785			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		9,579,838			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,579,838			61.00
62.00	Deductibles billed to program beneficiaries		930,714			62.00

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		27,961			63.00
64.00	Allowable bad debts (see instructions)		179,827			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		116,888			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		138,323			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,738,051			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		-267			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-2,008			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		-17,003			70.93
70.94	HRR adjustment amount (see instructions)		-130,648			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
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,588,125			71.00
71.01	Sequestration adjustment (see instructions)		171,763			71.01
72.00	Interim payments		8,066,560			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)		349,802			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		234,536			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

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		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	50,937		70,579	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.994203		1.00039	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-295		28	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.9880		0.9802	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-611		-1,397	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part B Date/Time Prepared: 9/29/2015 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	757	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,587,858	2.00
3.00	PPS payments	4,808,605	3.00
4.00	Outlier payment (see instructions)	46,754	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	757	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,030	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	2,030	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	2,030	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,273	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)	757	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,855,359	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	4,084	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,023,647	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,828,385	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,828,385	30.00
31.00	Primary payer payments	1,314	31.00
32.00	Subtotal (line 30 minus line 31)	3,827,071	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	157,106	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	102,119	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	128,467	36.00
37.00	Subtotal (see instructions)	3,929,190	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,929,190	40.00
40.01	Sequestration adjustment (see instructions)	78,584	40.01
41.00	Interim payments	3,907,063	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-56,457	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		7,901,212		3,749,996	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		165,348		157,067	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,066,560		3,907,063	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		349,802		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		56,457	6.02
7.00	Total Medicare program liability (see instructions)		8,416,362		3,850,606	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,442,981		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,442,981		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		9,323		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,452,304		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/29/2015 9:22 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,287,803		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,287,803		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		6,030		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,293,833		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140040	Period: From 05/01/2014 To 04/30/2015	Worksheet E-1 Part II Date/Time Prepared: 9/29/2015 9:22 am
	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, Pt. I col. 15 line 14	2,388	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	5,850	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,631	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	10,217	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	360,896,620	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	17,041	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,234,379	8.00
9.00	Sequestration adjustment amount (see instructions)	24,688	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,209,691	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,352,952	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)	-143,261	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2014 To 04/30/2015	Worksheet E-3 Part II Date/Time Prepared: 9/29/2015 9:22 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,579,904	1.00
2.00	Net IPF PPS Outlier Payments	770	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	6.178082	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,580,674	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1,580,674	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,580,674	18.00
19.00	Deductibles	108,240	19.00
20.00	Subtotal (line 18 minus line 19)	1,472,434	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	1,472,434	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	14,629	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	9,509	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,690	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,481,943	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,481,943	31.00
31.01	Sequestration adjustment (see instructions)	29,639	31.01
32.00	Interim payments	1,442,981	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	9,323	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	770	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 145690	Period: From 05/01/2014 To 04/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 9/29/2015 9:22 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,446,018	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,446,018	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	1,170	6.00
7.00	Coinsurance	130,764	7.00
8.00	Allowable bad debts (see instructions)	9,467	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	6,154	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,320,238	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,320,238	15.00
15.01	Sequestration adjustment (see instructions)	26,405	15.01
16.00	Interim payments	1,287,803	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	6,030	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G | Date/Time Prepared: 9/29/2015 9:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-426,630	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,014,831	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,502,307	0	0	0	6.00
7.00	Inventory	1,449,146	0	0	0	7.00
8.00	Prepaid expenses	532,305	0	0	0	8.00
9.00	Other current assets	-209,748	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)	10,857,597	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	433,029	0	0	0	12.00
13.00	Land improvements	583,160	0	0	0	13.00
14.00	Accumulated depreciation	-389,171	0	0	0	14.00
15.00	Buildings	15,668,667	0	0	0	15.00
16.00	Accumulated depreciation	-5,608,901	0	0	0	16.00
17.00	Leasehold improvements	9,449,610	0	0	0	17.00
18.00	Accumulated depreciation	-3,947,302	0	0	0	18.00
19.00	Fixed equipment	3,679,706	0	0	0	19.00
20.00	Accumulated depreciation	-1,155,893	0	0	0	20.00
21.00	Automobiles and trucks	31,608	0	0	0	21.00
22.00	Accumulated depreciation	-28,466	0	0	0	22.00
23.00	Major movable equipment	11,903,604	0	0	0	23.00
24.00	Accumulated depreciation	-8,158,838	0	0	0	24.00
25.00	Minor equipment depreciable	5,383,384	0	0	0	25.00
26.00	Accumulated depreciation	-3,850,281	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,993,916	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,275,425	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,275,425	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,126,938	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,640,341	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,912,596	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	23,213	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-118,097,120	0	0	0	43.00
44.00	Other current liabilities	904,166	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-112,616,804	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-112,616,804	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	150,743,742				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)	150,743,742	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,126,938	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-1 | Date/Time Prepared: 9/29/2015 9:22 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		137,252,255		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		13,491,487				2.00
3.00	Total (sum of line 1 and line 2)		150,743,742		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		150,743,742		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		150,743,742		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 9/29/2015 9:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	23,685,198		23,685,198	1.00
2.00	SUBPROVIDER - IPF	7,074,779		7,074,779	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,837,817		3,837,817	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	34,597,794		34,597,794	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,072,440		11,072,440	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)	11,072,440		11,072,440	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45,670,234		45,670,234	17.00
18.00	Ancillary services	99,531,992	180,992,904	280,524,896	18.00
19.00	Outpatient services	5,963,719	28,737,771	34,701,490	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	INDUSTRIAL LAB REVENUE	0	-1,923,830	-1,923,830	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	151,165,945	207,806,845	358,972,790	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		60,718,889		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)		60,718,889		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-3 | Date/Time Prepared: 9/29/2015 9:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	358,972,790	1.00
2.00	Less contractual allowances and discounts on patients' accounts	286,359,949	2.00
3.00	Net patient revenues (line 1 minus line 2)	72,612,841	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,718,889	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,893,952	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,597,535	24.00
25.00	Total other income (sum of lines 6-24)	1,597,535	25.00
26.00	Total (line 5 plus line 25)	13,491,487	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	13,491,487	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 140040 | Period: From 05/01/2014 To 04/30/2015 | Worksheet I-5 | Date/Time Prepared: 9/29/2015 9:22 am

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140040	Period: From 05/01/2014 To 04/30/2015	Worksheet L Parts I-III Date/Time Prepared: 9/29/2015 9:22 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	626,738	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	27,047	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)	28.38	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)	653,785	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