

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: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet S Parts I-III Date/Time Prepared: 9/28/2015 9:43 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 9/28/2015 Time: 9:43 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CGH MEDICAL CENTER ( 140043 ) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-153,665	227,391	434,384	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-44		0	9.00
200.00 Total	0	-153,665	227,347	434,384	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: 140043		Period: From 05/01/2014 To 04/30/2015		Worksheet S-2 Part I Date/Time Prepared: 9/28/2015 8:44 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 100 EAST LEFEVRE ROAD		PO Box:					1.00				
2.00	City: STERLING		State: IL		Zip Code: 61081-1279		County: WHITESIDE					
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		CGH MEDICAL CENTER		140043	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF		CGH MEDICAL CENTER		140043	99914		01/13/2004	N	P	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA		CGH HOME NURSING		147562	99914		05/05/1994	N	P	N	12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					05/01/2014		04/30/2015		20.00		
21.00	Type of Control (see instructions)							12		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.							1		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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.			2,316	468	0	0	9	116	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: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/28/2015 8:44 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)(iii)? 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	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	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		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
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	
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<b>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.</b>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	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

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		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
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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
<b>Inpatient Rehabilitation Facility PPS</b>						
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)				N N 0	76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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

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		V	XIX		
		1.00	2.00		
<b>Title V and XIX Services</b>					
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
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	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)	N	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				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
<b>Miscellaneous Cost Reporting Information</b>					
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.	Y			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 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,209,241	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.	N			121.00
<b>Transplant Center Information</b>					
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: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/28/2015 8:44 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)	N		140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
		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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
					1.00
Multi campus					
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	165.00
		Name	County	State	Zip Code
		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
					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
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/28/2015 8:44 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2013	09/30/2014 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: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part II Date/Time Prepared: 9/28/2015 8:44 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for 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	
		Y/N	Date	Y/N	
		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	08/14/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet S-2  
Part II  
Date/Time Prepared:  
9/28/2015 8:44 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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
				1.00	
				2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	
				2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		KWELLEN@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet S-2  
Part II  
Date/Time Prepared:  
9/28/2015 8:44 am

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
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)	08/14/2015		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	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 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	87	31,755	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)		87	31,755	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		95	34,675	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		95				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: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,473	1,639	12,928			1.00
2.00 HMO and other (see instructions)	1,042	468				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	7,473	1,639	12,928			7.00
8.00 INTENSIVE CARE UNIT	908	127	1,419			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		559	988			13.00
14.00 Total (see instructions)	8,381	2,325	15,335	0.00	1,218.07	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	1,973	0	6,917	0.00	15.11	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	1,233.18	27.00
28.00 Observation Bed Days		0	3,690			28.00
29.00 Ambulance Trips	1,432					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	116	188			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: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	2,285	742	4,518	1.00
2.00 HMO and other (see instructions)			265	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	2,285	742	4,518	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140043		Period: From 05/01/2014 To 04/30/2015		Worksheet S-3 Part II Date/Time Prepared: 9/28/2015 8:44 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		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	86,178,000	0	86,178,000	2,565,063.70	33.60	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		1,967,782	0	1,967,782	14,469.75	135.99	3.00
4.00	Physician-Part A - Administrative		143,830	0	143,830	958.87	150.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		29,308,976	0	29,308,976	180,016.00	162.81	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,433,844	273,650	3,707,494	150,632.80	24.61	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		433,043	0	433,043	7,475.50	57.93	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		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	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
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		25,018,339	0	25,018,339			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,737,449	0	1,737,449			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		370,638	0	370,638			21.00
22.00	Physician Part A - Administrative		26,964	0	26,964			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		4,936,749	0	4,936,749			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
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	417,653	0	417,653	13,009.47	32.10	26.00
27.00	Administrative & General	5.00	10,728,144	231,895	10,960,039	414,597.05	26.44	27.00
28.00	Administrative & General under contract (see inst.)		144,703	0	144,703	722.63	200.24	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,008,934	0	1,008,934	43,714.35	23.08	30.00
31.00	Laundry & Linen Service	8.00	250,913	0	250,913	22,154.34	11.33	31.00
32.00	Housekeeping	9.00	926,298	0	926,298	70,648.97	13.11	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	854,333	-628,732	225,601	16,128.03	13.99	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	628,732	628,732	44,947.49	13.99	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,152,773	-336,088	816,685	20,193.57	40.44	38.00
39.00	Central Services and Supply	14.00	387,316	0	387,316	19,832.88	19.53	39.00
40.00	Pharmacy	15.00	958,577	-958,577	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet S-3  
Part II  
Date/Time Prepared:  
9/28/2015 8:44 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es 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	1,522,580	0	1,522,580	81,534.66	18.67	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: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet S-3  
Part III  
Date/Time Prepared:  
9/28/2015 8:44 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	55,045,945	0	55,045,945	2,371,300.58	23.21	1.00
2.00	Excluded area salaries (see instructions)	3,433,844	273,650	3,707,494	150,632.80	24.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	51,612,101	-273,650	51,338,451	2,220,667.78	23.12	3.00
4.00	Subtotal other wages & related costs (see inst.)	433,043	0	433,043	7,475.50	57.93	4.00
5.00	Subtotal wage-related costs (see inst.)	25,045,303	0	25,045,303	0.00	48.78	5.00
6.00	Total (sum of lines 3 thru 5)	77,090,447	-273,650	76,816,797	2,228,143.28	34.48	6.00
7.00	Total overhead cost (see instructions)	18,352,224	-1,062,770	17,289,454	747,483.44	23.13	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 9/28/2015 8:44 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			2,986,027 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)			4,673,892 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
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
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			18,464,477 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			161,480 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			301,055 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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			3,879,653 17.00
18.00	Medicare Taxes - Employers Portion Only			1,218,324 18.00
19.00	Unemployment Insurance			129,132 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
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			276,099 23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>			<b>32,090,139 24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet S-3 Part V Date/Time Prepared: 9/28/2015 8:44 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	621,371	0	1.00
2.00	Hospital	621,371	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			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			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140043 Component CCN: 147562		Period: From 05/01/2014 To 04/30/2015		Worksheet S-4 Date/Time Prepared: 9/28/2015 8:44 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WHITESIDE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	356	0	2,514	2,870	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	366.00	62.00	229.00	657.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		1.93	0.00	1.93	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			9.99	0.00	9.99	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.77	0.00	1.77	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.01	0.01	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.03	0.07	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.38	0.00	1.38	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,205	60	174	3	1,442	21.00
22.00	Skilled Nursing Visit Charges	208,349	10,920	24,693	585	244,547	22.00
23.00	Physical Therapy Visits	365	10	24	0	399	23.00
24.00	Physical Therapy Visit Charges	63,926	1,830	3,453	0	69,209	24.00
25.00	Occupational Therapy Visits	8	0	0	0	8	25.00
26.00	Occupational Therapy Visit Charges	1,400	0	0	0	1,400	26.00
27.00	Speech Pathology Visits	21	0	0	0	21	27.00
28.00	Speech Pathology Visit Charges	3,700	0	0	0	3,700	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	78	15	0	10	103	31.00
32.00	Home Health Aide Visit Charges	6,460	1,275	0	765	8,500	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,677	85	198	13	1,973	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	283,835	14,025	28,146	1,350	327,356	35.00
36.00	Total Number of Episodes (standard/non outlier)	142		49	1	192	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	3,568	175	552	66	4,361	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet S-10 Date/Time Prepared: 9/28/2015 8:44 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.245552	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,075,551	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		7,050,462	5.00	
6.00	Medicaid charges		83,605,593	6.00	
7.00	Medicaid cost (line 1 times line 6)		20,529,521	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)		7,403,508	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		85,458	9.00	
10.00	Stand-alone SCHIP charges		1,154,677	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		283,533	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		198,075	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)		7,601,583	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,080,850	1,307,046	5,387,896	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,002,061	320,948	1,323,009	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)	1,002,061	320,948	1,323,009	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,463,118	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		942,662	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		5,520,456	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,355,559	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,678,568	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,280,151	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		10,680,302	10,680,302	-4,465,562	6,214,740	1.00
2.00	00200		0	0	6,969,851	6,969,851	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	417,653	31,946,682	32,364,335	299,450	32,663,785	4.00
5.00	00500	10,728,144	11,325,135	22,053,279	536,748	22,590,027	5.00
7.00	00700	1,008,934	2,421,860	3,430,794	-92,803	3,337,991	7.00
8.00	00800	250,913	119,490	370,403	0	370,403	8.00
9.00	00900	926,298	1,107,448	2,033,746	-21,759	2,011,987	9.00
10.00	01000	854,333	930,885	1,785,218	-1,313,801	471,417	10.00
11.00	01100	0	0	0	1,313,801	1,313,801	11.00
13.00	01300	1,152,773	117,127	1,269,900	-337,340	932,560	13.00
14.00	01400	387,316	264,611	651,927	-180,724	471,203	14.00
15.00	01500	958,577	4,007,165	4,965,742	-4,666,428	299,314	15.00
16.00	01600	1,522,580	942,223	2,464,803	0	2,464,803	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	9,967,818	843,479	10,811,297	-718,782	10,092,515	30.00
31.00	03100	1,975,537	186,500	2,162,037	-742,110	1,419,927	31.00
43.00	04300	0	0	0	448,495	448,495	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	1,354,127	4,712,246	6,066,373	-4,413,969	1,652,404	50.00
51.00	05100	826,327	209,039	1,035,366	-194,122	841,244	51.00
52.00	05200	0	0	0	820,535	820,535	52.00
53.00	05300	1,967,782	667,448	2,635,230	-479,037	2,156,193	53.00
53.01	05301	308,471	70,253	378,724	-57,839	320,885	53.01
54.00	05400	1,138,937	1,522,841	2,661,778	215,422	2,877,200	54.00
54.01	05401	378,967	613,855	992,822	54,486	1,047,308	54.01
56.00	05600	263,398	1,114,848	1,378,246	-926,225	452,021	56.00
57.00	05700	509,315	1,773,373	2,282,688	-48,031	2,234,657	57.00
58.00	05800	311,613	726,464	1,038,077	-747	1,037,330	58.00
59.00	05900	841,609	2,235,678	3,077,287	-1,991,304	1,085,983	59.00
60.00	06000	2,818,556	3,809,195	6,627,751	-1,532,406	5,095,345	60.00
65.00	06500	831,130	158,656	989,786	-129,755	860,031	65.00
66.00	06600	292,942	13,563	306,505	-6,848	299,657	66.00
67.00	06700	64,564	3,858	68,422	-2,825	65,597	67.00
68.00	06800	91,104	1,155	92,259	-125	92,134	68.00
69.00	06900	749,184	248,750	997,934	-110,971	886,963	69.00
70.00	07000	180,557	98,670	279,227	-17,740	261,487	70.00
71.00	07100	0	0	0	13,090,387	13,090,387	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	15,263,395	15,263,395	73.00
74.00	07400	0	66,183	66,183	-588	65,595	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	885,894	679,609	1,565,503	-567,673	997,830	75.01
76.00	03020	0	3,630	3,630	22,526	26,156	76.00
76.98	07698	769,823	526,544	1,296,367	-170,885	1,125,482	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	34,890,026	13,893,129	48,783,155	-12,931,761	35,851,394	90.00
91.00	09100	3,118,954	5,215,858	8,334,812	-444,306	7,890,506	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	1,483,689	333,213	1,816,902	-147,298	1,669,604	95.00
98.00	09850	59,051	183,910	242,961	-35,183	207,778	98.00
101.00	10100	954,930	170,360	1,125,290	-57,454	1,067,836	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		855,909	855,909	-855,909	0	113.00
118.00		85,241,826	104,801,144	190,042,970	1,372,786	191,415,756	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	24,281	45,824	70,105	0	70,105	190.00
192.00	19200	891,402	1,837,054	2,728,456	-1,658,947	1,069,509	192.00
194.00	07950	20,491	1,998	22,489	286,161	308,650	194.00
200.00		86,178,000	106,686,020	192,864,020	0	192,864,020	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-855,909	5,358,831	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-5,463	6,964,388	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,495,390	28,168,395	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,528,216	20,061,811	5.00
7.00	00700	OPERATION OF PLANT	-305,639	3,032,352	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	370,403	8.00
9.00	00900	HOUSEKEEPING	-565	2,011,422	9.00
10.00	01000	DIETARY	-7,206	464,211	10.00
11.00	01100	CAFETERIA	-798,819	514,982	11.00
13.00	01300	NURSING ADMINISTRATION	0	932,560	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	471,203	14.00
15.00	01500	PHARMACY	0	299,314	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-75,846	2,388,957	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,298,327	7,794,188	30.00
31.00	03100	INTENSIVE CARE UNIT	-5,064	1,414,863	31.00
43.00	04300	NURSERY	0	448,495	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,652,404	50.00
51.00	05100	RECOVERY ROOM	0	841,244	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	820,535	52.00
53.00	05300	ANESTHESIOLOGY	-2,091,839	64,354	53.00
53.01	05301	PAIN MANAGEMENT	-117,970	202,915	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,084,431	1,792,769	54.00
54.01	05401	ULTRASOUND	-439,414	607,894	54.01
56.00	05600	RADIOISOTOPE	-51,473	400,548	56.00
57.00	05700	CT SCAN	-1,381,978	852,679	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-536,546	500,784	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,085,983	59.00
60.00	06000	LABORATORY	-543,902	4,551,443	60.00
65.00	06500	RESPIRATORY THERAPY	-3,459	856,572	65.00
66.00	06600	PHYSICAL THERAPY	0	299,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	65,597	67.00
68.00	06800	SPEECH PATHOLOGY	0	92,134	68.00
69.00	06900	ELECTROCARDIOLOGY	-18,513	868,450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	261,487	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,090,387	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,263,395	73.00
74.00	07400	RENAL DIALYSIS	0	65,595	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	GI LAB	0	997,830	75.01
76.00	03020	DIABETIC EDUCATION	0	26,156	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	-548,897	576,585	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-27,452,675	8,398,719	90.00
91.00	09100	EMERGENCY	-4,588,285	3,302,221	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-1,415	1,668,189	95.00
98.00	09850	HOME INFUSION	-1,560	206,218	98.00
101.00	10100	HOME HEALTH AGENCY	-391	1,067,445	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-50,239,192	141,176,564	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	70,105	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,069,509	192.00
194.00	07950	COMMUNITY SERVICE	0	308,650	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-50,239,192	142,624,828	200.00

RECLASSIFICATIONS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-6

Date/Time Prepared:  
9/28/2015 8:44 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
<b>A - TO RECLASS INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	855,909	1.00
	O		0	855,909	
<b>B - TO RECLASS L&amp;D AND NURSERY COST</b>					
1.00	NURSERY	43.00	420,098	17,702	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	768,581	32,386	2.00
	O		1,188,679	50,088	
<b>C - TO RECLASS OFFSITE BLDG</b>					
1.00	OTHER CAP REL COSTS	3.00	0	20,478	1.00
2.00	OPERATION OF PLANT	7.00	0	355,837	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	183,058	3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,124,854	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,416	5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	21,059	6.00
	O		0	1,709,702	
<b>D - TO RECLASS EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	302,763	1.00
2.00		0.00	0	0	2.00
	O		0	302,763	
<b>E - TO RECLASS COLL AND BILLING EXP</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	63,830	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		0	63,830	
<b>F - TO RECLASS BOND AMORTIZATION</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	178,897	1.00
	O		0	178,897	
<b>G - TO RECLASS CAFETERIA EXPENSE</b>					
1.00	CAFETERIA	11.00	628,732	685,069	1.00
	O		628,732	685,069	
<b>H - TO RECLASS DRUG EXPENSE</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	958,577	14,304,818	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
	O		958,577	14,304,818	
<b>I - TO RECLASS MARKETING AND ADV</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,027	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
	O		0	7,027	
<b>J - TO RECLASS TELEPHONE EXPENSE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	135,109	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

RECLASSIFICATIONS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-6

Date/Time Prepared:  
9/28/2015 8:44 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
13.00		0.00	0	0	13.00
			0	135,109	
<b>K - TO RECLASS PROPERTY INSURANCE</b>					
1.00	OTHER CAP REL COSTS	3.00	0	180,690	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	322,613	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
			0	503,303	
<b>L - TO RECLASS MALPRACTICE INSURANCE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,200	1.00
			0	17,200	
<b>M - TO RECLASS MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,090,387	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
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
			0	13,090,387	
<b>N - TO RECLASS POPULATION HLTH MGMT</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	677,029	216,104	1.00
2.00	DIABETIC EDUCATION	76.00	23,589	1,875	2.00
3.00	COMMUNITY SERVICE	194.00	273,650	12,511	3.00
			974,268	230,490	
<b>O - TO RECLASS POST ICU</b>					
1.00	ADULTS & PEDIATRICS	30.00	649,792	22,540	1.00
			649,792	22,540	
<b>P - TO RECLASS MME DEPRECIATION</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,882,659	1.00
			0	6,882,659	
<b>Q - TO RECLASS UTILITIES EXPENSE</b>					
1.00	OPERATION OF PLANT	7.00	0	5,642	1.00
			0	5,642	
<b>R - TO RECLASS NURSING FLOATS</b>					
1.00	ADULTS & PEDIATRICS	30.00	262,695	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	43,130	0	2.00
3.00	NURSERY	43.00	10,695	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	19,568	0	4.00
			336,088	0	
<b>T - TO RECLASS RADIOLOGY MANAGEMENT</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	237,798	15,274	1.00
2.00	ULTRASOUND	54.01	55,160	3,543	2.00
3.00	RADIOISOTOPE	56.00	38,303	2,460	3.00
4.00	CT SCAN	57.00	84,785	5,446	4.00

RECLASSIFICATIONS

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Worksheet A-6

Date/Time Prepared:  
9/28/2015 8:44 am

Increases						
	Cost Center	Line #	Salary	Other		
5.00	2.00	3.00	4.00	5.00		
	MAGNETIC RESONANCE IMAGING (MRI)	58.00	44,088	2,832		5.00
			460,134	29,555		
U - TO RECLASS PHYSICIAN REMUNERATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	15,000	0		1.00
	TOTALS		15,000	0		
V - TO RECLASS RADIOLOGY TECHS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	26,049	0		1.00
2.00	ULTRASOUND	54.01	8,811	0		2.00
3.00	CT SCAN	57.00	8,847	0		3.00
	TOTALS		43,707	0		
500.00	Grand Total: Increases		5,254,977	39,074,988		500.00

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Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>A - TO RECLASS INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	855,909		11	1.00
	O		0	855,909			
<b>B - TO RECLASS L&amp;D AND NURSERY COST</b>							
1.00	ADULTS & PEDIATRICS	30.00	1,188,679	50,088		0	1.00
2.00	O	0.00	0	0		0	2.00
			1,188,679	50,088			
<b>C - TO RECLASS OFFSITE BLDG</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,684,227		0	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,416		9	2.00
3.00	HOUSEKEEPING	9.00	0	21,059		13	3.00
4.00	O	0.00	0	0		10	4.00
5.00		0.00	0	0		0	5.00
6.00		0.00	0	0		0	6.00
	O		0	1,709,702			
<b>D - TO RECLASS EMPLOYEE BENEFITS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	276,099		0	1.00
2.00	AMBULANCE SERVICES	95.00	0	26,664		0	2.00
	O		0	302,763			
<b>E - TO RECLASS COLL AND BILLING EXP</b>							
1.00	AMBULANCE SERVICES	95.00	0	43,440		0	1.00
2.00	HOME INFUSION	98.00	0	6,735		0	2.00
3.00	HOME HEALTH AGENCY	101.00	0	13,655		0	3.00
	O		0	63,830			
<b>F - TO RECLASS BOND AMORTIZATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	178,897		14	1.00
	O		0	178,897			
<b>G - TO RECLASS CAFETERIA EXPENSE</b>							
1.00	DIETARY	10.00	628,732	685,069		0	1.00
	O		628,732	685,069			
<b>H - TO RECLASS DRUG EXPENSE</b>							
1.00	NURSING ADMINISTRATION	13.00	0	132		0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	134		0	2.00
3.00	PHARMACY	15.00	958,577	3,582,982		0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	10,496		0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	3,964		0	5.00
6.00	RECOVERY ROOM	51.00	0	289		0	6.00
7.00	ANESTHESIOLOGY	53.00	0	275,695		0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,316		0	8.00
9.00	RADIOISOTOPE	56.00	0	315,328		0	9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	3,740		0	10.00
11.00	LABORATORY	60.00	0	459		0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	752		0	12.00
13.00	PHYSICAL THERAPY	66.00	0	15		0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	42		0	14.00
15.00	GI LAB	75.01	0	1,236		0	15.00
16.00	DIABETIC EDUCATION	76.00	0	8		0	16.00
17.00	HYPERBARIC OXYGEN THERAPY	76.98	0	10,481		0	17.00
18.00	CLINIC	90.00	0	10,085,288		0	18.00
19.00	EMERGENCY	91.00	0	5,516		0	19.00
20.00	AMBULANCE SERVICES	95.00	0	5,945		0	20.00
	O		958,577	14,304,818			
<b>I - TO RECLASS MARKETING AND ADV</b>							
1.00	NURSING ADMINISTRATION	13.00	0	1,120		0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	999		0	2.00
3.00	CT SCAN	57.00	0	1,758		0	3.00
4.00	HYPERBARIC OXYGEN THERAPY	76.98	0	1,326		0	4.00
5.00	CLINIC	90.00	0	542		0	5.00
6.00	HOME INFUSION	98.00	0	495		0	6.00
7.00	HOME HEALTH AGENCY	101.00	0	787		0	7.00
	O		0	7,027			
<b>J - TO RECLASS TELEPHONE EXPENSE</b>							
1.00	OPERATION OF PLANT	7.00	0	680		0	1.00
2.00	PHARMACY	15.00	0	912		0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	9,781		0	3.00
4.00	OPERATING ROOM	50.00	0	3,205		0	4.00
5.00	ANESTHESIOLOGY	53.00	0	2,061		0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	559		0	6.00
7.00	LABORATORY	60.00	0	2,377		0	7.00
8.00	ELECTROCARDIOLOGY	69.00	0	256		0	8.00
9.00	CLINIC	90.00	0	100,870		0	9.00
10.00	EMERGENCY	91.00	0	418		0	10.00
11.00	AMBULANCE SERVICES	95.00	0	8,789		0	11.00
12.00	HOME HEALTH AGENCY	101.00	0	5,006		0	12.00

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	195	0		13.00
	0		0	135,109			
K - TO RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,660	0		1.00
2.00	HOUSEKEEPING	9.00	0	700	13		2.00
3.00	OPERATION OF PLANT	7.00	0	130,989	0		3.00
4.00	LABORATORY	60.00	0	159	0		4.00
5.00	CLINIC	90.00	0	1,401	0		5.00
6.00	AMBULANCE SERVICES	95.00	0	18,873	0		6.00
7.00	HOME HEALTH AGENCY	101.00	0	20,908	0		7.00
8.00	OPERATION OF PLANT	7.00	0	322,613	0		8.00
	0		0	503,303			
L - TO RECLASS MALPRACTICE INSURANCE							
1.00	AMBULANCE SERVICES	95.00	0	17,200	0		1.00
	0		0	17,200			
M - TO RECLASS MEDICAL SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,313	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	180,590	0		2.00
3.00	PHARMACY	15.00	0	123,957	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	394,765	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	108,944	0		5.00
6.00	OPERATING ROOM	50.00	0	4,410,764	0		6.00
7.00	RECOVERY ROOM	51.00	0	193,833	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	201,281	0		8.00
9.00	PAIN MANAGEMENT	53.01	0	57,839	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	59,825	0		10.00
11.00	ULTRASOUND	54.01	0	13,028	0		11.00
12.00	RADIOISOTOPE	56.00	0	651,660	0		12.00
13.00	CT SCAN	57.00	0	145,351	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	47,667	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	1,987,564	0		15.00
16.00	LABORATORY	60.00	0	1,529,411	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	129,003	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	6,833	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	2,825	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	125	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	110,673	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	17,740	0		22.00
23.00	RENAL DIALYSIS	74.00	0	588	0		23.00
24.00	GI LAB	75.01	0	566,437	0		24.00
25.00	DIABETIC EDUCATION	76.00	0	2,930	0		25.00
26.00	HYPERBARIC OXYGEN THERAPY	76.98	0	159,078	0		26.00
27.00	CLINIC	90.00	0	1,480,195	0		27.00
28.00	EMERGENCY	91.00	0	438,372	0		28.00
29.00	AMBULANCE SERVICES	95.00	0	20,745	0		29.00
30.00	HOME INFUSION	98.00	0	27,953	0		30.00
31.00	HOME HEALTH AGENCY	101.00	0	17,098	0		31.00
	0		0	13,090,387			
N - TO RECLASS POPULATION HLTH MGMT							
1.00	CLINIC	90.00	974,268	230,490	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		974,268	230,490			
O - TO RECLASS POST ICU							
1.00	INTENSIVE CARE UNIT	31.00	649,792	22,540	0		1.00
	0		649,792	22,540			
P - TO RECLASS MME DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,882,659	9		1.00
	0		0	6,882,659			
Q - TO RECLASS UTILITIES EXPENSE							
1.00	AMBULANCE SERVICES	95.00	0	5,642	0		1.00
	0		0	5,642			
R - TO RECLASS NURSING FLOATS							
1.00	NURSING ADMINISTRATION	13.00	336,088	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		336,088	0			
T - TO RECLASS RADIOLOGY MANAGEMENT							
1.00	ADMINISTRATIVE & GENERAL	5.00	460,134	29,555	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00

RECLASSIFICATIONS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-6

Date/Time Prepared:  
9/28/2015 8:44 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
5.00		0.00	0	0	0	0	5.00
			460,134	29,555			
U - TO RECLASS PHYSICIAN REMUNERATION							
1.00	CLINIC	90.00	15,000	0	0	0	1.00
	TOTALS		15,000	0			
V - TO RECLASS RADIOLOGY TECHS							
1.00	CLINIC	90.00	43,707	0	0	0	1.00
2.00		0.00	0	0	0	0	2.00
3.00		0.00	0	0	0	0	3.00
	TOTALS		43,707	0			
500.00	Grand Total: Decreases		5,254,977	39,074,988			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-7  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,649,399	0	0	0	1.00
2.00	Land Improvements	3,760,155	208,055	0	208,055	2.00
3.00	Buildings and Fixtures	80,328,214	7,786,043	0	7,786,043	3.00
4.00	Building Improvements	13,736,151	0	0	0	4.00
5.00	Fixed Equipment	455,583	129,685	0	129,685	5.00
6.00	Movable Equipment	63,025,341	19,777,605	0	19,777,605	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	163,954,843	27,901,388	0	27,901,388	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	163,954,843	27,901,388	0	27,901,388	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,649,399	0			1.00
2.00	Land Improvements	3,968,210	0			2.00
3.00	Buildings and Fixtures	88,114,257	0			3.00
4.00	Building Improvements	13,736,151	0			4.00
5.00	Fixed Equipment	513,113	0			5.00
6.00	Movable Equipment	82,465,028	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	191,446,158	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	191,446,158	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-7  
Part II  
Date/Time Prepared:  
9/28/2015 8:44 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	10,680,302	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,680,302	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	10,680,302				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	10,680,302				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-7  
Part III  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	108,468,017	0	108,468,017	0.566572	113,976	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	82,978,141	0	82,978,141	0.433428	87,192	2.00
3.00	Total (sum of lines 1-2)	191,446,158	0	191,446,158	1.000000	201,168	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	113,976	3,793,227	1,124,854	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	87,192	6,877,196	0	2.00
3.00	Total (sum of lines 1-2)	0	0	201,168	10,670,423	1,124,854	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	113,976	505,671	-178,897	5,358,831	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	87,192	0	0	6,964,388	2.00
3.00	Total (sum of lines 1-2)	0	201,168	505,671	-178,897	12,323,219	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-8

Date/Time Prepared:  
9/28/2015 8:44 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center		Line #		
				1.00	2.00	3.00		4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-855,909	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00		0 2.00
3.00	Investment income - other (chapter 2)		0			0.00		0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-30,985	ADMINISTRATIVE & GENERAL		5.00		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)	B	-53	ADMINISTRATIVE & GENERAL		5.00		0 7.00
8.00	Television and radio service (chapter 21)		0			0.00		0 8.00
9.00	Parking lot (chapter 21)		0			0.00		0 9.00
10.00	Provider-based physician adjustment	A-8-2	-39,108,572					0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0			0.00		0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0					0 12.00
13.00	Laundry and linen service		0			0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-796,659	CAFETERIA		11.00		0 14.00
15.00	Rental of quarters to employee and others		0			0.00		0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00		0 16.00
17.00	Sale of drugs to other than patients		0			0.00		0 17.00
18.00	Sale of medical records and abstracts	B	-75,846	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	-2,160	CAFETERIA		11.00		0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00		0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00		0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00		0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00		0 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00	Physicians' assistant		0			0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00		0 32.00
33.00	DAYCARE RENT	B	-18,000	ADMINISTRATIVE & GENERAL		5.00		0 33.00
33.01	DIETARY CATERING REVENUE	B	-7,206	DIETARY		10.00		0 33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-8

Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02 RENTAL INCOME	B	-1,755	OPERATION OF PLANT		7.00	0 33.02
33.03 MISCELLANEOUS INCOME	B	-1,230	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.03
33.04 MISCELLANEOUS INCOME	B	-51,113	ADMINISTRATIVE & GENERAL		5.00	0 33.04
33.05 MISCELLANEOUS INCOME	B	-3,459	RESPIRATORY THERAPY		65.00	0 33.05
33.06 MISCELLANEOUS INCOME	B	-1,000	RADIOLOGY-DIAGNOSTIC		54.00	0 33.06
33.07 CARDIAC REHAB PHASE III REVENUE	B	-18,513	ELECTROCARDIOLOGY		69.00	0 33.07
33.08 MISCELLANEOUS INCOME	B	-6,400	CT SCAN		57.00	0 33.08
33.09 BLOOD DRAW INCOME	B	-1,560	HOME INFUSION		98.00	0 33.09
33.10 MISCELLANEOUS INCOME	B	-1,415	AMBULANCE SERVICES		95.00	0 33.10
33.11 MISCELLANEOUS INCOME	B	-303,884	OPERATION OF PLANT		7.00	0 33.11
33.12 HOUSEKEEPING REVENUE	B	-565	HOUSEKEEPING		9.00	0 33.12
33.13 PATIENT ACCOUNTING REVENUE	B	-63,266	ADMINISTRATIVE & GENERAL		5.00	0 33.13
33.14 DAYCARE REVENUE	B	-557,190	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.15 MISCELLANEOUS INCOME	B	-60	RADIOLOGY-DIAGNOSTIC		54.00	0 33.15
33.16 MISCELLANEOUS INCOME	B	-30	ADULTS & PEDIATRICS		30.00	0 33.16
33.17 HOME NURSING INCOME	B	-391	HOME HEALTH AGENCY		101.00	0 33.17
33.18 LOBBYING EXPENSE	A	-47,420	ADMINISTRATIVE & GENERAL		5.00	0 33.18
33.19 PHYSICIAN RECRUITMENT SALARIES	A	-78,418	ADMINISTRATIVE & GENERAL		5.00	0 33.19
33.20 PHYSICIAN RECRUITMENT OTHER	A	-372,393	ADMINISTRATIVE & GENERAL		5.00	0 33.20
33.21 PHYSICIAN RECRUITMENT BENEFITS	A	-56,947	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.21
33.22 PHYSICIAN RECRUITMENT DEPRECIATION	A	-133	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.22
33.23 MARKETING OTHER EXPENSES	A	-617,093	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24 MARKETING DEPRECIATION	A	-5,330	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.24
33.25 MARKETING BENEFITS	A	-90,408	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.25
33.26 MARKETING SALARIES	A	-231,006	ADMINISTRATIVE & GENERAL		5.00	0 33.26
33.27 CABLE TELEVISION	A	-49,176	ADMINISTRATIVE & GENERAL		5.00	0 33.27
33.28 CABLE TELEVISION	A	-3,053	CLINIC		90.00	0 33.28
33.29 DAYCARE DISCOUNT EXPENSE ELIMINATION	A	-41,621	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.29
33.30 PHYSICIAN BENEFITS	A	-3,935,147	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.30
33.31 CRNA LOCUM TENENS	A	-84,096	ANESTHESIOLOGY		53.00	0 33.31
33.32 CRNA PHYSICIAN CME EXPENSE	A	-7,310	ANESTHESIOLOGY		53.00	0 33.32
33.33 CRNA FICA TAXES	A	-53,510	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.33
33.34 CRNA MEDICARE TAXES	A	-28,171	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.34
33.35 CRNA BENEFIT OFFSET	A	-288,356	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.35
33.36 CRNA SALARIES	A	-1,967,782	ANESTHESIOLOGY		53.00	0 33.36
33.37 CRNA MALPRACTICE INSURANCE	A	-32,651	ANESTHESIOLOGY		53.00	0 33.37
33.38 ALCOHOLIC BEVERAGES	A	-2,514	ADMINISTRATIVE & GENERAL		5.00	0 33.38
33.39 DONATION EXPENSE	A	-339,436	ADMINISTRATIVE & GENERAL		5.00	0 33.39
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-50,239,192				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet A-8-2

Date/Time Prepared:  
9/28/2015 8:44 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	5.00 AGGREGATE-ADMINISTRATIVE & GENERAL	143,830	0	143,830	159,800	959	1.00
2.00	30.00 AGGREGATE-ADULTS & PEDIATRICS	2,298,297	2,298,297	0	0	0	2.00
3.00	31.00 AGGREGATE-INTENSIVE CARE UNIT	5,064	5,064	0	0	0	3.00
4.00	53.01 AGGREGATE-PAIN MANAGEMENT	117,970	117,970	0	0	0	4.00
5.00	54.00 AGGREGATE-RADIOLOGY-DIAGNOSTIC	1,083,371	1,083,371	0	0	0	5.00
6.00	54.01 AGGREGATE-ULTRASOUND	439,414	439,414	0	0	0	6.00
7.00	56.00 AGGREGATE-RADIOISOTOPE	51,473	51,473	0	0	0	7.00
8.00	57.00 AGGREGATE-CT SCAN	1,375,578	1,375,578	0	0	0	8.00
9.00	58.00 AGGREGATE-MAGNETIC RESONANCE IMAGING	536,546	536,546	0	0	0	9.00
10.00	60.00 AGGREGATE-LABORATORY	543,902	543,902	0	0	0	10.00
11.00	76.98 AGGREGATE-HYPERBARIC OXYGEN THERAPY	548,897	548,897	0	0	0	11.00
12.00	90.00 AGGREGATE-CLINIC	27,449,622	27,449,622	0	0	0	12.00
13.00	91.00 AGGREGATE-EMERGENCY	4,588,285	4,588,285	0	0	0	13.00
200.00		39,182,249	39,038,419	143,830		959	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	5.00 AGGREGATE-ADMINISTRATIVE & GENERAL	73,677	3,684	0	0	0	1.00
2.00	30.00 AGGREGATE-ADULTS & PEDIATRICS	0	0	24,513	0	99,101	2.00
3.00	31.00 AGGREGATE-INTENSIVE CARE UNIT	0	0	0	0	5,064	3.00
4.00	53.01 AGGREGATE-PAIN MANAGEMENT	0	0	0	0	786	4.00
5.00	54.00 AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	690	0	0	5.00
6.00	54.01 AGGREGATE-ULTRASOUND	0	0	0	0	0	6.00
7.00	56.00 AGGREGATE-RADIOISOTOPE	0	0	0	0	0	7.00
8.00	57.00 AGGREGATE-CT SCAN	0	0	0	0	0	8.00
9.00	58.00 AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	0	0	9.00
10.00	60.00 AGGREGATE-LABORATORY	0	0	0	0	14,837	10.00
11.00	76.98 AGGREGATE-HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	11.00
12.00	90.00 AGGREGATE-CLINIC	0	0	237,087	0	966,306	12.00
13.00	91.00 AGGREGATE-EMERGENCY	0	0	0	0	0	13.00
200.00		73,677	3,684	262,290	0	1,086,094	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	5.00 AGGREGATE-ADMINISTRATIVE & GENERAL	0	73,677	70,153	70,153	1.00
2.00	30.00 AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,298,297	2.00
3.00	31.00 AGGREGATE-INTENSIVE CARE UNIT	0	0	0	5,064	3.00
4.00	53.01 AGGREGATE-PAIN MANAGEMENT	0	0	0	117,970	4.00
5.00	54.00 AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	1,083,371	5.00
6.00	54.01 AGGREGATE-ULTRASOUND	0	0	0	439,414	6.00
7.00	56.00 AGGREGATE-RADIOISOTOPE	0	0	0	51,473	7.00
8.00	57.00 AGGREGATE-CT SCAN	0	0	0	1,375,578	8.00
9.00	58.00 AGGREGATE-MAGNETIC RESONANCE IMAGING	0	0	0	536,546	9.00
10.00	60.00 AGGREGATE-LABORATORY	0	0	0	543,902	10.00
11.00	76.98 AGGREGATE-HYPERBARIC OXYGEN THERAPY	0	0	0	548,897	11.00
12.00	90.00 AGGREGATE-CLINIC	0	0	0	27,449,622	12.00
13.00	91.00 AGGREGATE-EMERGENCY	0	0	0	4,588,285	13.00
200.00		0	73,677	70,153	39,108,572	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period: From 05/01/2014 To 04/30/2015

Worksheet B Part I Date/Time Prepared: 9/28/2015 8:44 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	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,358,831	5,358,831			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	6,964,388		6,964,388		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	28,168,395	8,640	4,330	28,181,365	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,061,811	931,161	2,121,936	5,540,459	5.00
7.00 00700	OPERATION OF PLANT	3,032,352	177,521	639,976	524,846	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	370,403	68,245	18,634	130,525	8.00
9.00 00900	HOUSEKEEPING	2,011,422	7,096	7,454	481,859	9.00
10.00 01000	DIETARY	464,211	23,426	22,979	117,357	10.00
11.00 01100	CAFETERIA	514,982	65,272	64,040	327,066	11.00
13.00 01300	NURSING ADMINISTRATION	932,560	1,918	24,642	424,839	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	471,203	10,021	25,649	201,481	14.00
15.00 01500	PHARMACY	299,314	17,299	22,375	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,388,957	58,982	69,512	792,045	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	7,794,188	497,632	306,872	3,959,372	30.00
31.00 03100	INTENSIVE CARE UNIT	1,414,863	97,482	99,297	712,087	31.00
43.00 04300	NURSERY	448,495	82,657	42,715	224,098	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,652,404	233,473	573,924	704,416	50.00
51.00 05100	RECOVERY ROOM	841,244	95,612	66,915	429,854	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	820,535	97,194	78,154	409,994	52.00
53.00 05300	ANESTHESIOLOGY	64,354	6,137	5,273	0	53.00
53.01 05301	PAIN MANAGEMENT	202,915	16,752	6,204	99,507	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,792,769	165,660	461,647	729,727	54.00
54.01 05401	ULTRASOUND	607,894	28,010	66,357	230,416	54.01
56.00 05600	RADIOISOTOPE	400,548	66,030	139,036	156,945	56.00
57.00 05700	CT SCAN	852,679	18,142	69,162	313,652	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	500,784	38,519	50,155	185,035	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,085,983	75,370	424,826	437,804	59.00
60.00 06000	LABORATORY	4,551,443	116,708	238,093	1,190,991	60.00
65.00 06500	RESPIRATORY THERAPY	856,572	49,997	78,265	432,353	65.00
66.00 06600	PHYSICAL THERAPY	299,657	8,966	4,196	152,388	66.00
67.00 06700	OCCUPATIONAL THERAPY	65,597	3,845	0	33,586	67.00
68.00 06800	SPEECH PATHOLOGY	92,134	1,151	0	47,392	68.00
69.00 06900	ELECTROCARDIOLOGY	868,450	38,970	123,346	389,725	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	261,487	12,571	18,824	93,926	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,090,387	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	15,263,395	0	0	498,651	73.00
74.00 07400	RENAL DIALYSIS	65,595	1,966	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	GI LAB	997,830	33,744	188,393	460,841	75.01
76.00 03020	DIABETIC EDUCATION	26,156	14,911	2,863	12,271	76.00
76.98 07698	HYPERBARI C OXYGEN THERAPY	576,585	25,075	13,507	136,485	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	8,398,719	1,907,646	530,865	4,048,260	90.00
91.00 09100	EMERGENCY	3,302,221	83,913	240,103	1,622,477	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	1,668,189	30,282	66,222	771,814	95.00
98.00 09850	HOME INFUSION	206,218	2,014	0	30,718	98.00
101.00 10100	HOME HEALTH AGENCY	1,067,445	22,247	26,213	496,754	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	141,176,564	5,242,257	6,942,954	27,552,016	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,105	12,149	2,362	12,631	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,069,509	73,596	18,659	463,706	192.00
194.00 07950	COMMUNITY SERVICE	308,650	30,829	413	153,012	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	142,624,828	5,358,831	6,964,388	28,181,365	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period: From 05/01/2014 To 04/30/2015

Worksheet B Part I Date/Time Prepared: 9/28/2015 8:44 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	28,655,367				5.00	
7.00	00700	OPERATION OF PLANT	1,099,930	5,474,625			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	147,792	88,086	823,685		8.00	
9.00	00900	HOUSEKEEPING	630,544	9,159	50,847	3,198,381	9.00	
10.00	01000	DIETARY	157,891	30,236	5,297	17,984	839,381	10.00
11.00	01100	CAFETERIA	244,229	84,249	14,759	50,110	0	11.00
13.00	01300	NURSING ADMINISTRATION	347,969	2,475	0	1,472	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	178,101	12,934	0	7,693	0	14.00
15.00	01500	PHARMACY	85,232	22,328	0	13,280	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	832,107	76,130	0	45,281	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,157,474	642,306	376,415	382,033	757,430	30.00
31.00	03100	INTENSIVE CARE UNIT	584,255	125,822	38,947	74,837	81,951	31.00
43.00	04300	NURSERY	200,632	106,688	9,002	63,456	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	795,579	301,350	48,872	179,238	0	50.00
51.00	05100	RECOVERY ROOM	360,456	123,409	13,512	73,402	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	353,480	125,451	16,471	74,616	0	52.00
53.00	05300	ANESTHESIOLOGY	19,049	7,921	0	4,711	0	53.00
53.01	05301	PAIN MANAGEMENT	81,810	21,622	2,014	12,861	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	791,955	213,821	40,172	127,178	0	54.00
54.01	05401	ULTRASOUND	234,503	36,153	0	21,503	0	54.01
56.00	05600	RADIOISOTOPE	191,730	85,227	0	50,691	0	56.00
57.00	05700	CT SCAN	315,201	23,417	0	13,928	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	194,731	49,718	0	29,571	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	508,890	97,282	9,378	57,862	0	59.00
60.00	06000	LABORATORY	1,533,028	150,638	413	89,597	0	60.00
65.00	06500	RESPIRATORY THERAPY	356,323	64,533	0	38,383	0	65.00
66.00	06600	PHYSICAL THERAPY	116,967	11,572	15	6,883	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,904	4,963	0	2,952	0	67.00
68.00	06800	SPEECH PATHOLOGY	35,370	1,485	0	883	0	68.00
69.00	06900	ELECTROCARDIOLOGY	357,154	50,299	7,721	29,917	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,255	16,226	5,343	9,651	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,291,316	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	3,963,077	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,987	2,537	77	1,509	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	422,606	43,554	42,766	25,905	0	75.01
76.00	03020	DIABETIC EDUCATION	14,131	19,246	0	11,447	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	188,988	32,365	5,724	19,250	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3,742,659	2,462,251	24,669	1,464,509	0	90.00
91.00	09100	EMERGENCY	1,319,684	108,309	66,542	64,421	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	637,754	39,086	27,262	23,248	0	95.00
98.00	09850	HOME INFUSION	60,079	2,599	0	1,546	0	98.00
101.00	10100	HOME HEALTH AGENCY	405,471	28,714	0	17,079	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,098,293	5,324,161	806,218	3,108,887	839,381	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,451	15,681	0	9,327	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	408,692	94,992	17,233	56,500	0	192.00
194.00	07950	COMMUNITY SERVICE	123,931	39,791	234	23,667	0	194.00
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)	28,655,367	5,474,625	823,685	3,198,381	839,381	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet B  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,364,707					11.00
13.00	01300	14,209	1,750,084				13.00
14.00	01400	13,960	0	921,042			14.00
15.00	01500	0	0	0	459,828		15.00
16.00	01600	57,363	0	0	0	4,320,377	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	233,329	478,156	365	0	267,422	30.00
31.00	03100	36,583	78,505	0	0	54,551	31.00
43.00	04300	9,073	19,467	0	0	21,081	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	30,979	66,474	2,160	0	267,808	50.00
51.00	05100	21,379	45,881	225	0	40,631	51.00
52.00	05200	16,594	35,617	0	0	38,508	52.00
53.00	05300	10,185	0	0	0	92,821	53.00
53.01	05301	4,331	8,677	0	0	44,802	53.01
54.00	05400	39,934	0	0	0	165,103	54.00
54.01	05401	9,263	0	0	0	94,201	54.01
56.00	05600	6,439	0	0	0	103,555	56.00
57.00	05700	14,238	0	0	0	417,050	57.00
58.00	05800	7,404	0	0	0	137,413	58.00
59.00	05900	19,214	41,239	5	0	215,344	59.00
60.00	06000	81,347	0	517	0	771,895	60.00
65.00	06500	22,901	0	276	0	36,054	65.00
66.00	06600	7,726	0	25	0	6,694	66.00
67.00	06700	1,039	0	0	0	1,132	67.00
68.00	06800	1,449	0	0	0	2,271	68.00
69.00	06900	22,784	48,905	619	0	134,782	69.00
70.00	07000	3,892	0	112	0	31,390	70.00
71.00	07100	0	0	911,065	0	164,474	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	20,165	0	0	459,828	364,270	73.00
74.00	07400	0	0	0	0	1,811	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	24,877	0	20	0	129,133	75.01
76.00	03020	1,288	0	0	0	3,591	76.00
76.98	07698	9,087	0	0	0	47,206	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	432,548	686,753	1,140	0	234,406	90.00
91.00	09100	85,181	182,776	1,887	0	374,525	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	50,368	0	0	0	40,218	95.00
98.00	09850	1,961	4,222	0	0	5,023	98.00
101.00	10100	22,111	47,450	331	0	11,212	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		1,333,201	1,744,122	918,747	459,828	4,320,377	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,551	0	613	0	0	190.00
192.00	19200	20,677	0	1,666	0	0	192.00
194.00	07950	9,278	5,962	16	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,364,707	1,750,084	921,042	459,828	4,320,377	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet B  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	18,852,994	0	18,852,994	30.00
31.00	03100	3,399,180	0	3,399,180	31.00
43.00	04300	1,227,364	0	1,227,364	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	4,856,677	0	4,856,677	50.00
51.00	05100	2,112,520	0	2,112,520	51.00
52.00	05200	2,066,614	0	2,066,614	52.00
53.00	05300	210,451	0	210,451	53.00
53.01	05301	501,495	0	501,495	53.01
54.00	05400	4,527,966	0	4,527,966	54.00
54.01	05401	1,328,300	0	1,328,300	54.01
56.00	05600	1,200,201	0	1,200,201	56.00
57.00	05700	2,037,469	0	2,037,469	57.00
58.00	05800	1,193,330	0	1,193,330	58.00
59.00	05900	2,973,197	0	2,973,197	59.00
60.00	06000	8,724,670	0	8,724,670	60.00
65.00	06500	1,935,657	0	1,935,657	65.00
66.00	06600	615,089	0	615,089	66.00
67.00	06700	139,018	0	139,018	67.00
68.00	06800	182,135	0	182,135	68.00
69.00	06900	2,072,672	0	2,072,672	69.00
70.00	07000	550,677	0	550,677	70.00
71.00	07100	17,457,242	0	17,457,242	71.00
72.00	07200	0	0	0	72.00
73.00	07300	20,569,386	0	20,569,386	73.00
74.00	07400	90,482	0	90,482	74.00
75.00	07500	0	0	0	75.00
75.01	07501	2,369,669	0	2,369,669	75.01
76.00	03020	105,904	0	105,904	76.00
76.98	07698	1,054,272	0	1,054,272	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	23,934,425	0	23,934,425	90.00
91.00	09100	7,452,039	0	7,452,039	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	3,354,443	0	3,354,443	95.00
98.00	09850	314,380	0	314,380	98.00
101.00	10100	2,145,027	0	2,145,027	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		139,554,945	0	139,554,945	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	148,870	0	148,870	190.00
192.00	19200	2,225,230	0	2,225,230	192.00
194.00	07950	695,783	0	695,783	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		142,624,828	0	142,624,828	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet B  
Part II  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,640	4,330	12,970	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	72,045	931,161	2,121,936	3,125,142	5.00
7.00 00700	OPERATION OF PLANT	4,500	177,521	639,976	821,997	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	68,245	18,634	86,879	8.00
9.00 00900	HOUSEKEEPING	0	7,096	7,454	14,550	9.00
10.00 01000	DIETARY	0	23,426	22,979	46,405	10.00
11.00 01100	CAFETERIA	0	65,272	64,040	129,312	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,918	24,642	26,560	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	10,021	25,649	35,670	14.00
15.00 01500	PHARMACY	0	17,299	22,375	39,674	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	58,982	69,512	128,494	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	497,632	306,872	804,504	30.00
31.00 03100	INTENSIVE CARE UNIT	0	97,482	99,297	196,779	31.00
43.00 04300	NURSERY	0	82,657	42,715	125,372	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	90,588	233,473	573,924	897,985	50.00
51.00 05100	RECOVERY ROOM	0	95,612	66,915	162,527	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	97,194	78,154	175,348	52.00
53.00 05300	ANESTHESIOLOGY	0	6,137	5,273	11,410	53.00
53.01 05301	PAIN MANAGEMENT	0	16,752	6,204	22,956	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	165,660	461,647	627,307	54.00
54.01 05401	ULTRASOUND	0	28,010	66,357	94,367	54.01
56.00 05600	RADIOLOGY-SOFT	0	66,030	139,036	205,066	56.00
57.00 05700	CT SCAN	0	18,142	69,162	87,304	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	38,519	50,155	88,674	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	75,370	424,826	500,196	59.00
60.00 06000	LABORATORY	0	116,708	238,093	354,801	60.00
65.00 06500	RESPIRATORY THERAPY	0	49,997	78,265	128,262	65.00
66.00 06600	PHYSICAL THERAPY	0	8,966	4,196	13,162	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	3,845	0	3,845	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,151	0	1,151	68.00
69.00 06900	ELECTROCARDIOLOGY	0	38,970	123,346	162,316	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,475	12,571	18,824	32,870	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	1,966	0	1,966	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	GI LAB	0	33,744	188,393	222,137	75.01
76.00 03020	DIABETIC EDUCATION	0	14,911	2,863	17,774	76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	25,075	13,507	38,582	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	1,907,646	530,865	2,438,511	90.00
91.00 09100	EMERGENCY	0	83,913	240,103	324,016	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	30,282	66,222	96,504	95.00
98.00 09850	HOME INFUSION	0	2,014	0	2,014	98.00
101.00 10100	HOME HEALTH AGENCY	0	22,247	26,213	48,460	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	168,608	5,242,257	6,942,954	12,353,819	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,149	2,362	14,511	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	69,760	73,596	18,659	162,015	192.00
194.00 07950	COMMUNITY SERVICE	0	30,829	413	31,242	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	238,368	5,358,831	6,964,388	12,561,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet B Part II Date/Time Prepared: 9/28/2015 8:44 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	3,127,711				5.00	
7.00	00700	OPERATION OF PLANT	120,055	942,293			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	16,131	15,161	118,231		8.00	
9.00	00900	HOUSEKEEPING	68,822	1,576	7,299	92,468	9.00	
10.00	01000	DIETARY	17,233	5,204	760	520	70,176	10.00
11.00	01100	CAFETERIA	26,657	14,501	2,119	1,449	0	11.00
13.00	01300	NURSING ADMINISTRATION	37,980	426	0	43	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,439	2,226	0	222	0	14.00
15.00	01500	PHARMACY	9,303	3,843	0	384	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,822	13,103	0	1,309	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	344,631	110,554	54,031	11,045	63,325	30.00
31.00	03100	INTENSIVE CARE UNIT	63,770	21,657	5,590	2,164	6,851	31.00
43.00	04300	NURSERY	21,899	18,363	1,292	1,835	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	86,836	51,868	7,015	5,182	0	50.00
51.00	05100	RECOVERY ROOM	39,343	21,241	1,939	2,122	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,581	21,593	2,364	2,157	0	52.00
53.00	05300	ANESTHESIOLOGY	2,079	1,363	0	136	0	53.00
53.01	05301	PAIN MANAGEMENT	8,929	3,722	289	372	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,440	36,803	5,766	3,677	0	54.00
54.01	05401	ULTRASOUND	25,595	6,223	0	622	0	54.01
56.00	05600	RADIOISOTOPE	20,927	14,669	0	1,466	0	56.00
57.00	05700	CT SCAN	34,404	4,031	0	403	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,254	8,557	0	855	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	55,544	16,744	1,346	1,673	0	59.00
60.00	06000	LABORATORY	167,326	25,928	59	2,590	0	60.00
65.00	06500	RESPIRATORY THERAPY	38,892	11,107	0	1,110	0	65.00
66.00	06600	PHYSICAL THERAPY	12,767	1,992	2	199	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,827	854	0	85	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,861	256	0	26	0	68.00
69.00	06900	ELECTROCARDIOLOGY	38,983	8,658	1,108	865	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,615	2,793	767	279	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,239	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	432,607	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,854	437	11	44	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	46,126	7,497	6,139	749	0	75.01
76.00	03020	DIABETIC EDUCATION	1,542	3,313	0	331	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	20,628	5,571	822	557	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	408,503	423,803	3,541	42,337	0	90.00
91.00	09100	EMERGENCY	144,040	18,642	9,551	1,862	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	69,609	6,727	3,913	672	0	95.00
98.00	09850	HOME INFUSION	6,558	447	0	45	0	98.00
101.00	10100	HOME HEALTH AGENCY	44,256	4,942	0	494	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,066,907	916,395	115,723	89,881	70,176	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,669	2,699	0	270	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,608	16,350	2,474	1,633	0	192.00
194.00	07950	COMMUNITY SERVICE	13,527	6,849	34	684	0	194.00
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)	3,127,711	942,293	118,231	92,468	70,176	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet B Part II Date/Time Prepared: 9/28/2015 8:44 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	174,188					11.00
13.00	01300	1,814	67,018				13.00
14.00	01400	1,782	0	59,432			14.00
15.00	01500	0	0	0	53,204		15.00
16.00	01600	7,322	0	0	0	241,414	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	29,782	18,311	24	0	14,951	30.00
31.00	03100	4,669	3,006	0	0	3,050	31.00
43.00	04300	1,158	745	0	0	1,179	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,954	2,546	139	0	14,972	50.00
51.00	05100	2,729	1,757	14	0	2,272	51.00
52.00	05200	2,118	1,364	0	0	2,153	52.00
53.00	05300	1,300	0	0	0	5,189	53.00
53.01	05301	553	332	0	0	2,505	53.01
54.00	05400	5,097	0	0	0	9,230	54.00
54.01	05401	1,182	0	0	0	5,266	54.01
56.00	05600	822	0	0	0	5,789	56.00
57.00	05700	1,817	0	0	0	23,316	57.00
58.00	05800	945	0	0	0	7,682	58.00
59.00	05900	2,452	1,579	0	0	12,039	59.00
60.00	06000	10,383	0	33	0	43,032	60.00
65.00	06500	2,923	0	18	0	2,016	65.00
66.00	06600	986	0	2	0	374	66.00
67.00	06700	133	0	0	0	63	67.00
68.00	06800	185	0	0	0	127	68.00
69.00	06900	2,908	1,873	40	0	7,535	69.00
70.00	07000	497	0	7	0	1,755	70.00
71.00	07100	0	0	58,789	0	9,195	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,574	0	0	53,204	20,365	73.00
74.00	07400	0	0	0	0	101	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	3,175	0	1	0	7,219	75.01
76.00	03020	164	0	0	0	201	76.00
76.98	07698	1,160	0	0	0	2,639	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	55,210	26,299	74	0	13,105	90.00
91.00	09100	10,872	6,999	122	0	20,938	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	6,429	0	0	0	2,248	95.00
98.00	09850	250	162	0	0	281	98.00
101.00	10100	2,822	1,817	21	0	627	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		170,167	66,790	59,284	53,204	241,414	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	198	0	40	0	0	190.00
192.00	19200	2,639	0	107	0	0	192.00
194.00	07950	1,184	228	1	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		174,188	67,018	59,432	53,204	241,414	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet B Part II Date/Time Prepared: 9/28/2015 8:44 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	1,452,977	0	1,452,977
31.00	03100	INTENSIVE CARE UNIT	307,863	0	307,863
43.00	04300	NURSERY	171,946	0	171,946
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	1,070,821	0	1,070,821
51.00	05100	RECOVERY ROOM	234,141	0	234,141
52.00	05200	DELIVERY ROOM & LABOR ROOM	245,866	0	245,866
53.00	05300	ANESTHESIOLOGY	21,477	0	21,477
53.01	05301	PAIN MANAGEMENT	39,704	0	39,704
54.00	05400	RADIOLOGY-DIAGNOSTIC	774,655	0	774,655
54.01	05401	ULTRASOUND	133,361	0	133,361
56.00	05600	RADIOISOTOPE	248,811	0	248,811
57.00	05700	CT SCAN	151,419	0	151,419
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	128,052	0	128,052
59.00	05900	CARDIAC CATHETERIZATION	591,774	0	591,774
60.00	06000	LABORATORY	604,699	0	604,699
65.00	06500	RESPIRATORY THERAPY	184,527	0	184,527
66.00	06600	PHYSICAL THERAPY	29,554	0	29,554
67.00	06700	OCCUPATIONAL THERAPY	7,822	0	7,822
68.00	06800	SPEECH PATHOLOGY	5,628	0	5,628
69.00	06900	ELECTROCARDIOLOGY	224,465	0	224,465
70.00	07000	ELECTROENCEPHALOGRAPHY	49,626	0	49,626
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	427,223	0	427,223
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	508,979	0	508,979
74.00	07400	RENAL DIALYSIS	4,413	0	4,413
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0
75.01	07501	GI LAB	293,255	0	293,255
76.00	03020	DIABETIC EDUCATION	23,331	0	23,331
76.98	07698	HYPERBARIC OXYGEN THERAPY	70,022	0	70,022
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	3,413,243	0	3,413,243
91.00	09100	EMERGENCY	537,787	0	537,787
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	186,457	0	186,457
98.00	09850	HOME INFUSION	9,771	0	9,771
101.00	10100	HOME HEALTH AGENCY	103,667	0	103,667
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,257,336	0	12,257,336
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,393	0	20,393
192.00	19200	PHYSICIANS' PRIVATE OFFICES	230,039	0	230,039
194.00	07950	COMMUNITY SERVICE	53,819	0	53,819
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,561,587	0	12,561,587

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet B-1  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	558,851				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		6,882,659			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	901	4,279	54,174,165		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	97,107	2,097,040	10,650,615	-28,655,367	5.00
7.00 00700	OPERATION OF PLANT	18,513	632,465	1,008,934	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	7,117	18,415	250,913	0	8.00
9.00 00900	HOUSEKEEPING	740	7,367	926,298	0	9.00
10.00 01000	DIETARY	2,443	22,709	225,601	0	10.00
11.00 01100	CAFETERIA	6,807	63,288	628,732	0	11.00
13.00 01300	NURSING ADMINISTRATION	200	24,353	816,685	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,045	25,348	387,316	0	14.00
15.00 01500	PHARMACY	1,804	22,112	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,151	68,696	1,522,580	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	51,896	303,271	7,611,265	0	30.00
31.00 03100	INTENSIVE CARE UNIT	10,166	98,132	1,368,875	0	31.00
43.00 04300	NURSERY	8,620	42,214	430,793	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	24,348	567,189	1,354,127	0	50.00
51.00 05100	RECOVERY ROOM	9,971	66,130	826,327	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,136	77,237	788,149	0	52.00
53.00 05300	ANESTHESIOLOGY	640	5,211	0	0	53.00
53.01 05301	PAIN MANAGEMENT	1,747	6,131	191,287	0	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,276	456,229	1,402,784	0	54.00
54.01 05401	ULTRASOUND	2,921	65,578	442,938	0	54.01
56.00 05600	RADIOISOTOPE	6,886	137,404	301,701	0	56.00
57.00 05700	CT SCAN	1,892	68,350	602,947	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,017	49,566	355,701	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	7,860	419,840	841,609	0	59.00
60.00 06000	LABORATORY	12,171	235,299	2,289,491	0	60.00
65.00 06500	RESPIRATORY THERAPY	5,214	77,347	831,130	0	65.00
66.00 06600	PHYSICAL THERAPY	935	4,147	292,942	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	401	0	64,564	0	67.00
68.00 06800	SPEECH PATHOLOGY	120	0	91,104	0	68.00
69.00 06900	ELECTROCARDIOLOGY	4,064	121,898	749,184	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,311	18,603	180,557	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	958,577	0	73.00
74.00 07400	RENAL DIALYSIS	205	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	GI LAB	3,519	186,182	885,894	0	75.01
76.00 03020	DIABETIC EDUCATION	1,555	2,829	23,589	0	76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	2,615	13,348	262,371	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	198,941	524,635	7,782,137	0	90.00
91.00 09100	EMERGENCY	8,751	237,285	3,118,954	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	3,158	65,445	1,483,689	0	95.00
98.00 09850	HOME INFUSION	210	0	59,051	0	98.00
101.00 10100	HOME HEALTH AGENCY	2,320	25,905	954,930	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	546,694	6,861,477	52,964,341	-28,655,367	111,753,840
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,267	2,334	24,281	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	7,675	18,440	891,402	0	192.00
194.00 07950	COMMUNITY SERVICE	3,215	408	294,141	0	194.00
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)	5,358,831	6,964,388	28,181,365		28,655,367
203.00	Unit cost multiplier (Wkst. B, Part I)	9.589016	1.011875	0.520199		0.251430
204.00	Cost to be allocated (per Wkst. B, Part II)			12,970		3,127,711
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000239		0.027443

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet B-1

Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	442,330					7.00
8.00	00800	7,117	1,074,136				8.00
9.00	00900	740	66,308	434,473			9.00
10.00	01000	2,443	6,908	2,443	57,829		10.00
11.00	01100	6,807	19,247	6,807	0	93,260	11.00
13.00	01300	200	0	200	0	971	13.00
14.00	01400	1,045	0	1,045	0	954	14.00
15.00	01500	1,804	0	1,804	0	0	15.00
16.00	01600	6,151	0	6,151	0	3,920	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	51,896	490,867	51,896	52,183	15,945	30.00
31.00	03100	10,166	50,789	10,166	5,646	2,500	31.00
43.00	04300	8,620	11,739	8,620	0	620	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	24,348	63,732	24,348	0	2,117	50.00
51.00	05100	9,971	17,620	9,971	0	1,461	51.00
52.00	05200	10,136	21,479	10,136	0	1,134	52.00
53.00	05300	640	0	640	0	696	53.00
53.01	05301	1,747	2,627	1,747	0	296	53.01
54.00	05400	17,276	52,387	17,276	0	2,729	54.00
54.01	05401	2,921	0	2,921	0	633	54.01
56.00	05600	6,886	0	6,886	0	440	56.00
57.00	05700	1,892	0	1,892	0	973	57.00
58.00	05800	4,017	0	4,017	0	506	58.00
59.00	05900	7,860	12,229	7,860	0	1,313	59.00
60.00	06000	12,171	538	12,171	0	5,559	60.00
65.00	06500	5,214	0	5,214	0	1,565	65.00
66.00	06600	935	20	935	0	528	66.00
67.00	06700	401	0	401	0	71	67.00
68.00	06800	120	0	120	0	99	68.00
69.00	06900	4,064	10,069	4,064	0	1,557	69.00
70.00	07000	1,311	6,967	1,311	0	266	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	1,378	73.00
74.00	07400	205	101	205	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	3,519	55,770	3,519	0	1,700	75.01
76.00	03020	1,555	0	1,555	0	88	76.00
76.98	07698	2,615	7,465	2,615	0	621	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	198,941	32,170	198,941	0	29,559	90.00
91.00	09100	8,751	86,775	8,751	0	5,821	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	3,158	35,551	3,158	0	3,442	95.00
98.00	09850	210	0	210	0	134	98.00
101.00	10100	2,320	0	2,320	0	1,511	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		430,173	1,051,358	422,316	57,829	91,107	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,267	0	1,267	0	106	190.00
192.00	19200	7,675	22,473	7,675	0	1,413	192.00
194.00	07950	3,215	305	3,215	0	634	194.00
200.00							200.00
201.00							201.00
202.00		5,474,625	823,685	3,198,381	839,381	1,364,707	202.00
203.00		12.376789	0.766835	7.361518	14.514880	14.633358	203.00
204.00		942,293	118,231	92,468	70,176	174,188	204.00
205.00		2.130294	0.110071	0.212828	1.213509	1.867768	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet B-1  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	1,159,268				13.00
14.00	01400	0	13,233,709			14.00
15.00	01500	0	0	14,304,818		15.00
16.00	01600	0	0	0	568,331,645	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	316,734	5,240	0	35,177,794	30.00
31.00	03100	52,002	0	0	7,175,811	31.00
43.00	04300	12,895	0	0	2,773,066	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	44,033	31,032	0	35,228,594	50.00
51.00	05100	30,392	3,227	0	5,344,745	51.00
52.00	05200	23,593	0	0	5,065,561	52.00
53.00	05300	0	0	0	12,210,134	53.00
53.01	05301	5,748	0	0	5,893,395	53.01
54.00	05400	0	0	0	21,718,357	54.00
54.01	05401	0	0	0	12,391,586	54.01
56.00	05600	0	0	0	13,622,069	56.00
57.00	05700	0	0	0	54,860,625	57.00
58.00	05800	0	0	0	18,075,840	58.00
59.00	05900	27,317	71	0	28,327,233	59.00
60.00	06000	0	7,423	0	101,549,144	60.00
65.00	06500	0	3,964	0	4,742,743	65.00
66.00	06600	0	357	0	880,570	66.00
67.00	06700	0	0	0	148,951	67.00
68.00	06800	0	0	0	298,713	68.00
69.00	06900	32,395	8,887	0	17,729,790	69.00
70.00	07000	0	1,614	0	4,129,219	70.00
71.00	07100	0	13,090,387	0	21,635,634	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	14,304,818	47,917,696	73.00
74.00	07400	0	0	0	238,186	74.00
75.00	07500	0	0	0	0	75.00
75.01	07501	0	285	0	16,986,709	75.01
76.00	03020	0	0	0	472,370	76.00
76.98	07698	0	0	0	6,209,695	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	454,910	16,376	0	30,834,785	90.00
91.00	09100	121,072	27,117	0	49,266,648	91.00
92.00	09200					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	0	0	5,290,435	95.00
98.00	09850	2,797	0	0	660,726	98.00
101.00	10100	31,431	4,755	0	1,474,821	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300					113.00
118.00		1,155,319	13,200,735	14,304,818	568,331,645	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	8,812	0	0	190.00
192.00	19200	0	23,934	0	0	192.00
194.00	07950	3,949	228	0	0	194.00
200.00						200.00
201.00						201.00
202.00		1,750,084	921,042	459,828	4,320,377	202.00
203.00		1.509646	0.069598	0.032145	0.007602	203.00
204.00		67,018	59,432	53,204	241,414	204.00
205.00		0.057811	0.004491	0.003719	0.000425	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet C  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 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		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	18,852,994		18,852,994	0	18,852,994	30.00
31.00	03100 INTENSIVE CARE UNIT	3,399,180		3,399,180	0	3,399,180	31.00
43.00	04300 NURSERY	1,227,364		1,227,364	0	1,227,364	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,856,677		4,856,677	0	4,856,677	50.00
51.00	05100 RECOVERY ROOM	2,112,520		2,112,520	0	2,112,520	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,066,614		2,066,614	0	2,066,614	52.00
53.00	05300 ANESTHESIOLOGY	210,451		210,451	0	210,451	53.00
53.01	05301 PAIN MANAGEMENT	501,495		501,495	0	501,495	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,527,966		4,527,966	0	4,527,966	54.00
54.01	05401 ULTRASOUND	1,328,300		1,328,300	0	1,328,300	54.01
56.00	05600 RADIOISOTOPE	1,200,201		1,200,201	0	1,200,201	56.00
57.00	05700 CT SCAN	2,037,469		2,037,469	0	2,037,469	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,193,330		1,193,330	0	1,193,330	58.00
59.00	05900 CARDIAC CATHETERIZATION	2,973,197		2,973,197	0	2,973,197	59.00
60.00	06000 LABORATORY	8,724,670		8,724,670	0	8,724,670	60.00
65.00	06500 RESPIRATORY THERAPY	1,935,657	0	1,935,657	0	1,935,657	65.00
66.00	06600 PHYSICAL THERAPY	615,089	0	615,089	0	615,089	66.00
67.00	06700 OCCUPATIONAL THERAPY	139,018	0	139,018	0	139,018	67.00
68.00	06800 SPEECH PATHOLOGY	182,135	0	182,135	0	182,135	68.00
69.00	06900 ELECTROCARDIOLOGY	2,072,672		2,072,672	0	2,072,672	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	550,677		550,677	0	550,677	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,457,242		17,457,242	0	17,457,242	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	20,569,386		20,569,386	0	20,569,386	73.00
74.00	07400 RENAL DIALYSIS	90,482		90,482	0	90,482	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501 GI LAB	2,369,669		2,369,669	0	2,369,669	75.01
76.00	03020 DIABETIC EDUCATION	105,904		105,904	0	105,904	76.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,054,272		1,054,272	0	1,054,272	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	23,934,425		23,934,425	0	23,934,425	90.00
91.00	09100 EMERGENCY	7,452,039		7,452,039	0	7,452,039	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,186,268		4,186,268	0	4,186,268	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	3,354,443		3,354,443	0	3,354,443	95.00
98.00	09850 HOME INFUSION	314,380		314,380	0	314,380	98.00
101.00	10100 HOME HEALTH AGENCY	2,145,027		2,145,027	0	2,145,027	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	143,741,213	0	143,741,213	0	143,741,213	200.00
201.00	Less Observation Beds	4,186,268		4,186,268		4,186,268	201.00
202.00	Total (see instructions)	139,554,945	0	139,554,945	0	139,554,945	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140043		Period: From 05/01/2014 To 04/30/2015		Worksheet C Part I Date/Time Prepared: 9/28/2015 8:44 am	
			Title XVII I		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	29,511,566		29,511,566			30.00
31.00	03100	INTENSIVE CARE UNIT	7,175,811		7,175,811			31.00
43.00	04300	NURSERY	2,773,066		2,773,066			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	12,892,920	22,335,674	35,228,594	0.137862	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,258,154	4,086,591	5,344,745	0.395252	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,395,052	1,670,509	5,065,561	0.407973	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,488,692	6,721,442	12,210,134	0.017236	0.000000	53.00
53.01	05301	PAIN MANAGEMENT	21,956	5,871,439	5,893,395	0.085094	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,819,530	18,898,827	21,718,357	0.208486	0.000000	54.00
54.01	05401	ULTRASOUND	1,339,196	11,052,390	12,391,586	0.107194	0.000000	54.01
56.00	05600	RADIOISOTOPE	1,652,371	11,969,698	13,622,069	0.088107	0.000000	56.00
57.00	05700	CT SCAN	12,205,950	42,654,675	54,860,625	0.037139	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,794,267	16,281,573	18,075,840	0.066018	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,274,790	18,052,443	28,327,233	0.104959	0.000000	59.00
60.00	06000	LABORATORY	24,122,375	77,426,769	101,549,144	0.085916	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,096,677	1,646,066	4,742,743	0.408130	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	803,222	77,348	880,570	0.698512	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	88,170	60,781	148,951	0.933314	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	75,656	223,057	298,713	0.609732	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,427,689	13,302,101	17,729,790	0.116903	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	102,467	4,026,752	4,129,219	0.133361	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,461,608	11,174,026	21,635,634	0.806875	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,252,279	29,665,417	47,917,696	0.429265	0.000000	73.00
74.00	07400	RENAL DIALYSIS	208,858	29,328	238,186	0.379880	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
75.01	07501	GI LAB	1,879,886	15,106,823	16,986,709	0.139501	0.000000	75.01
76.00	03020	DIABETIC EDUCATION	557	471,813	472,370	0.224197	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	74,036	6,135,659	6,209,695	0.169778	0.000000	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	73,979	30,760,806	30,834,785	0.776215	0.000000	90.00
91.00	09100	EMERGENCY	10,522,618	38,744,030	49,266,648	0.151259	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,118,554	4,547,674	5,666,228	0.738810	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	490	5,289,945	5,290,435	0.634058	0.000000	95.00
98.00	09850	HOME INFUSION	0	660,726	660,726	0.475810	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY	0	1,474,821	1,474,821			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	167,912,442	400,419,203	568,331,645			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	167,912,442	400,419,203	568,331,645			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet C Part I Date/Time Prepared: 9/28/2015 8:44 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.137862		50.00
51.00	05100 RECOVERY ROOM	0.395252		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.407973		52.00
53.00	05300 ANESTHESIOLOGY	0.017236		53.00
53.01	05301 PAIN MANAGEMENT	0.085094		53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.208486		54.00
54.01	05401 ULTRASOUND	0.107194		54.01
56.00	05600 RADIOISOTOPE	0.088107		56.00
57.00	05700 CT SCAN	0.037139		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.066018		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.104959		59.00
60.00	06000 LABORATORY	0.085916		60.00
65.00	06500 RESPIRATORY THERAPY	0.408130		65.00
66.00	06600 PHYSICAL THERAPY	0.698512		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.933314		67.00
68.00	06800 SPEECH PATHOLOGY	0.609732		68.00
69.00	06900 ELECTROCARDIOLOGY	0.116903		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.133361		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.806875		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.429265		73.00
74.00	07400 RENAL DIALYSIS	0.379880		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501 GI LAB	0.139501		75.01
76.00	03020 DIABETIC EDUCATION	0.224197		76.00
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.169778		76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.776215		90.00
91.00	09100 EMERGENCY	0.151259		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.738810		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.634058		95.00
98.00	09850 HOME INFUSION	0.475810		98.00
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140043		Period: From 05/01/2014 To 04/30/2015		Worksheet D Part I Date/Time Prepared: 9/28/2015 8:44 am	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,452,977	0	1,452,977	16,618	87.43	30.00
31.00	INTENSIVE CARE UNIT	307,863		307,863	1,419	216.96	31.00
43.00	NURSERY	171,946		171,946	988	174.03	43.00
200.00	Total (Lines 30-199)	1,932,786		1,932,786	19,025		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	7,473	653,364				
31.00	INTENSIVE CARE UNIT	908	197,000				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	8,381	850,364				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet D Part II Date/Time Prepared: 9/28/2015 8:44 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,070,821	35,228,594	0.030396	5,132,624	156,011	50.00
51.00	05100	RECOVERY ROOM	234,141	5,344,745	0.043808	559,088	24,493	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	245,866	5,065,561	0.048537	94,643	4,594	52.00
53.00	05300	ANESTHESIOLOGY	21,477	12,210,134	0.001759	2,451,115	4,312	53.00
53.01	05301	PAIN MANAGEMENT	39,704	5,893,395	0.006737	1,913	13	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	774,655	21,718,357	0.035668	1,733,829	61,842	54.00
54.01	05401	ULTRASOUND	133,361	12,391,586	0.010762	746,268	8,031	54.01
56.00	05600	RADIOISOTOPE	248,811	13,622,069	0.018265	1,127,684	20,597	56.00
57.00	05700	CT SCAN	151,419	54,860,625	0.002760	6,966,059	19,226	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	128,052	18,075,840	0.007084	963,679	6,827	58.00
59.00	05900	CARDIAC CATHETERIZATION	591,774	28,327,233	0.020891	5,281,272	110,331	59.00
60.00	06000	LABORATORY	604,699	101,549,144	0.005955	14,714,643	87,626	60.00
65.00	06500	RESPIRATORY THERAPY	184,527	4,742,743	0.038907	2,100,133	81,710	65.00
66.00	06600	PHYSICAL THERAPY	29,554	880,570	0.033562	551,431	18,507	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,822	148,951	0.052514	50,570	2,656	67.00
68.00	06800	SPEECH PATHOLOGY	5,628	298,713	0.018841	59,884	1,128	68.00
69.00	06900	ELECTROCARDIOLOGY	224,465	17,729,790	0.012660	2,864,640	36,266	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	49,626	4,129,219	0.012018	62,807	755	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	427,223	21,635,634	0.019746	5,687,290	112,301	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	508,979	47,917,696	0.010622	10,019,035	106,422	73.00
74.00	07400	RENAL DIALYSIS	4,413	238,186	0.018528	135,642	2,513	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	GI LAB	293,255	16,986,709	0.017264	1,239,188	21,393	75.01
76.00	03020	DIABETIC EDUCATION	23,331	472,370	0.049391	518	26	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	70,022	6,209,695	0.011276	11,524	130	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3,413,243	30,834,785	0.110695	69,132	7,653	90.00
91.00	09100	EMERGENCY	537,787	49,266,648	0.010916	6,296,425	68,732	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	322,631	5,666,228	0.056939	652,443	37,149	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	HOME INFUSION	9,771	660,726	0.014788	0	0	98.00
200.00		Total (Lines 50-199)	10,357,057	522,105,946		69,573,479	1,001,244	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140043		Period: From 05/01/2014 To 04/30/2015		Worksheet D Part III Date/Time Prepared: 9/28/2015 8:44 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,618	0.00	7,473	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,419	0.00	908	0		31.00
43.00	04300	NURSERY	988	0.00	0	0		43.00
200.00		Total (lines 30-199)	19,025		8,381	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet D  
Part IV  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description		Title XVIII				Hospital		PPS	
		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			
<b>ANCILLARY SERVICE COST CENTERS</b>									
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	
53.01	05301	PAIN MANAGEMENT	0	0	0	0	0	53.01	
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
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	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00	
75.01	07501	GI LAB	0	0	0	0	0	75.01	
76.00	03020	DIABETIC EDUCATION	0	0	0	0	0	76.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
98.00	09850	HOME INFUSION	0	0	0	0	0	98.00	
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: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet D Part IV Date/Time Prepared: 9/28/2015 8:44 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	35,228,594	0.000000	0.000000	5,132,624	50.00
51.00	05100 RECOVERY ROOM	0	5,344,745	0.000000	0.000000	559,088	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5,065,561	0.000000	0.000000	94,643	52.00
53.00	05300 ANESTHESIOLOGY	0	12,210,134	0.000000	0.000000	2,451,115	53.00
53.01	05301 PAIN MANAGEMENT	0	5,893,395	0.000000	0.000000	1,913	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	21,718,357	0.000000	0.000000	1,733,829	54.00
54.01	05401 ULTRASOUND	0	12,391,586	0.000000	0.000000	746,268	54.01
56.00	05600 RADIO SOTOPE	0	13,622,069	0.000000	0.000000	1,127,684	56.00
57.00	05700 CT SCAN	0	54,860,625	0.000000	0.000000	6,966,059	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	18,075,840	0.000000	0.000000	963,679	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	28,327,233	0.000000	0.000000	5,281,272	59.00
60.00	06000 LABORATORY	0	101,549,144	0.000000	0.000000	14,714,643	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,742,743	0.000000	0.000000	2,100,133	65.00
66.00	06600 PHYSICAL THERAPY	0	880,570	0.000000	0.000000	551,431	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	148,951	0.000000	0.000000	50,570	67.00
68.00	06800 SPEECH PATHOLOGY	0	298,713	0.000000	0.000000	59,884	68.00
69.00	06900 ELECTROCARDIOLOGY	0	17,729,790	0.000000	0.000000	2,864,640	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	4,129,219	0.000000	0.000000	62,807	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,635,634	0.000000	0.000000	5,687,290	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	47,917,696	0.000000	0.000000	10,019,035	73.00
74.00	07400 RENAL DIALYSIS	0	238,186	0.000000	0.000000	135,642	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501 GI LAB	0	16,986,709	0.000000	0.000000	1,239,188	75.01
76.00	03020 DIABETIC EDUCATION	0	472,370	0.000000	0.000000	518	76.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	6,209,695	0.000000	0.000000	11,524	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	30,834,785	0.000000	0.000000	69,132	90.00
91.00	09100 EMERGENCY	0	49,266,648	0.000000	0.000000	6,296,425	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5,666,228	0.000000	0.000000	652,443	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	09850 HOME INFUSION	0	660,726	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	522,105,946			69,573,479	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet D Part IV Date/Time Prepared: 9/28/2015 8:44 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
Title XVIII						
Hospital						
PPS						
11.00						
12.00						
13.00						
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	6,057,558	0	50.00
51.00	05100	RECOVERY ROOM	0	1,513,824	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	225,738	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,837,462	0	53.00
53.01	05301	PAIN MANAGEMENT	0	3,056,549	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,353,706	0	54.00
54.01	05401	ULTRASOUND	0	2,776,911	0	54.01
56.00	05600	RADIOISOTOPE	0	5,601,249	0	56.00
57.00	05700	CT SCAN	0	15,779,662	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,409,847	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,182,657	0	59.00
60.00	06000	LABORATORY	0	16,346,324	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	580,013	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	277	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,554,034	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,339,073	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,859,136	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,678,120	0	73.00
74.00	07400	RENAL DIALYSIS	0	14,664	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	0	5,338,465	0	75.01
76.00	03020	DIABETIC EDUCATION	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,732,652	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	15,375,287	0	90.00
91.00	09100	EMERGENCY	0	10,337,956	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,019,151	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
98.00	09850	HOME INFUSION	0	0	0	98.00
200.00		Total (Lines 50-199)	0	131,970,315	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet D Part V Date/Time Prepared: 9/28/2015 8:44 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.137862	6,057,558	0	0	835,107	50.00
51.00	05100	RECOVERY ROOM	0.395252	1,513,824	0	0	598,342	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.407973	225,738	0	0	92,095	52.00
53.00	05300	ANESTHESIOLOGY	0.017236	1,837,462	0	0	31,670	53.00
53.01	05301	PAIN MANAGEMENT	0.085094	3,056,549	0	0	260,094	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208486	5,353,706	0	0	1,116,173	54.00
54.01	05401	ULTRASOUND	0.107194	2,776,911	0	0	297,668	54.01
56.00	05600	RADIO SOTOPE	0.088107	5,601,249	0	0	493,509	56.00
57.00	05700	CT SCAN	0.037139	15,779,662	0	0	586,041	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.066018	4,409,847	0	0	291,129	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104959	9,182,657	0	0	963,802	59.00
60.00	06000	LABORATORY	0.085916	16,346,324	10,643	0	1,404,411	60.00
65.00	06500	RESPIRATORY THERAPY	0.408130	580,013	0	0	236,721	65.00
66.00	06600	PHYSICAL THERAPY	0.698512	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.933314	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.609732	277	0	0	169	68.00
69.00	06900	ELECTROCARDIOLOGY	0.116903	4,554,034	0	0	532,380	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.133361	1,339,073	0	0	178,580	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.806875	4,859,136	0	0	3,920,715	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429265	12,678,120	273	176,650	5,442,273	73.00
74.00	07400	RENAL DIALYSIS	0.379880	14,664	0	0	5,571	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	GI LAB	0.139501	5,338,465	0	0	744,721	75.01
76.00	03020	DIABETIC EDUCATION	0.224197	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.169778	2,732,652	0	0	463,944	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.776215	15,375,287	72	0	11,934,528	90.00
91.00	09100	EMERGENCY	0.151259	10,337,956	0	0	1,563,709	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.738810	2,019,151	0	0	1,491,769	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0.634058	0	0	0	0	95.00
98.00	09850	HOME INFUSION	0.475810	0	0	0	0	98.00
200.00		Subtotal (see instructions)		131,970,315	10,988	176,650	33,485,121	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		131,970,315	10,988	176,650	33,485,121	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet D Part V Date/Time Prepared: 9/28/2015 8:44 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
53.01 05301 PAIN MANAGEMENT	0	0		53.01
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 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	914	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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	117	75,830		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01 07501 GI LAB	0	0		75.01
76.00 03020 DIABETIC EDUCATION	0	0		76.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	56	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
98.00 09850 HOME INFUSION	0	0		98.00
200.00	Subtotal (see instructions)	1,087	75,830	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,087	75,830	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet D-1 Date/Time Prepared: 9/28/2015 8:44 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,618	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,618	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)		12,928	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		7,473	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
<b>SWING BED ADJUSTMENT</b>				
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)		18,852,994	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)		18,852,994	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		18,852,994	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,134.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,478,044	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)		8,478,044	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043		Period: From 05/01/2014 To 04/30/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 9/28/2015 8:44 am	
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)		
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	3,399,180	1,419	2,395.48	908	2,175,096		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)					15,964,885		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,618,025		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)					850,364		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,001,244		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,851,608		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,766,417		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)					3,690		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,134.49		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,186,268		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043		Period: From 05/01/2014 To 04/30/2015		Worksheet D-1 Date/Time Prepared: 9/28/2015 8:44 am	
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	1,452,977	18,852,994	0.077069	4,186,268	322,631	90.00
91.00	Nursing School cost	0	18,852,994	0.000000	4,186,268	0	91.00
92.00	Allied health cost	0	18,852,994	0.000000	4,186,268	0	92.00
93.00	All other Medical Education	0	18,852,994	0.000000	4,186,268	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet D-3 Date/Time Prepared: 9/28/2015 8:44 am	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		13,134,878	30.00
31.00	03100	INTENSIVE CARE UNIT		3,987,213	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.137862	5,132,624	707,594 50.00
51.00	05100	RECOVERY ROOM	0.395252	559,088	220,981 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.407973	94,643	38,612 52.00
53.00	05300	ANESTHESIOLOGY	0.017236	2,451,115	42,247 53.00
53.01	05301	PAIN MANAGEMENT	0.085094	1,913	163 53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.208486	1,733,829	361,479 54.00
54.01	05401	ULTRASOUND	0.107194	746,268	79,995 54.01
56.00	05600	RADIOISOTOPE	0.088107	1,127,684	99,357 56.00
57.00	05700	CT SCAN	0.037139	6,966,059	258,712 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.066018	963,679	63,620 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104959	5,281,272	554,317 59.00
60.00	06000	LABORATORY	0.085916	14,714,643	1,264,223 60.00
65.00	06500	RESPIRATORY THERAPY	0.408130	2,100,133	857,127 65.00
66.00	06600	PHYSICAL THERAPY	0.698512	551,431	385,181 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.933314	50,570	47,198 67.00
68.00	06800	SPEECH PATHOLOGY	0.609732	59,884	36,513 68.00
69.00	06900	ELECTROCARDIOLOGY	0.116903	2,864,640	334,885 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.133361	62,807	8,376 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.806875	5,687,290	4,588,932 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429265	10,019,035	4,300,821 73.00
74.00	07400	RENAL DIALYSIS	0.379880	135,642	51,528 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
75.01	07501	GI LAB	0.139501	1,239,188	172,868 75.01
76.00	03020	DIABETIC EDUCATION	0.224197	518	116 76.00
76.98	07698	HYPERBARI C OXYGEN THERAPY	0.169778	11,524	1,957 76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.776215	69,132	53,661 90.00
91.00	09100	EMERGENCY	0.151259	6,296,425	952,391 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.738810	652,443	482,031 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			
98.00	09850	HOME INFUSION	0.475810	0	0 98.00
200.00		Total (sum of lines 50-94 and 96-98)		69,573,479	15,964,885 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		69,573,479	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part A Date/Time Prepared: 9/28/2015 8:44 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>					
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)		6,404,622		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,052,822		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)		265,497		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)		84.89		4.00
<b>Indirect Medical Education Adjustment</b>					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
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: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part A Date/Time Prepared: 9/28/2015 8:44 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1.00	1.01	29.01
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.07		30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.74		31.00
32.00	Sum of lines 30 and 31		21.81		32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.21		33.00
34.00	Disproportionate share adjustment (see instructions)		296,645		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000094483	0.000089627	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		854,731	685,434	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		358,284	398,115	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		756,399		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 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 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		17,775,985		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		19,632,814		48.00
49.00	Total payment for inpatient operating costs (see instructions)		19,168,607		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,330,817		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 instructions)		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)		20,499,424		59.00
60.00	Primary payer payments		3,740		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		20,495,684		61.00
62.00	Deductibles billed to program beneficiaries		2,019,040		62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part A Date/Time Prepared: 9/28/2015 8:44 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		4,582		63.00
64.00	Allowable bad debts (see instructions)		512,671		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		333,236		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		355,834		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		18,805,298		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)		8,587		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-2,907		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		105,356		70.93
70.94	HRR adjustment amount (see instructions)		-35,193		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)		18,881,141		71.00
71.01	Sequestration adjustment (see instructions)		377,623		71.01
72.00	Interim payments		18,657,183		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)		-153,665		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		264,908		75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part A Date/Time Prepared: 9/28/2015 8:44 am
		Title XVIII	Hospital	PPS
		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)	583,757		808,865
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.001606		1.009457
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	937		7,650
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9989		0.9972
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-642		-2,265

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet E Part B Date/Time Prepared: 9/28/2015 8:44 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		76,917	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		33,485,121	2.00
3.00	PPS payments		25,873,452	3.00
4.00	Outlier payment (see instructions)		375,205	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)		76,917	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		187,638	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)		187,638	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		187,638	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		110,721	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)		76,917	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)		26,248,657	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		5,574,543	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)		20,751,031	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)		20,751,031	30.00
31.00	Primary payer payments		942	31.00
32.00	Subtotal (line 30 minus line 31)		20,750,089	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		937,578	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		609,426	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		740,677	36.00
37.00	Subtotal (see instructions)		21,359,515	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00			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)		21,359,515	40.00
40.01	Sequestration adjustment (see instructions)		427,190	40.01
41.00	Interim payments		20,704,934	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		227,391	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 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		18,446,436		20,695,426	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		110,140		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	11/18/2014	100,607	11/18/2014	9,508	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)		100,607		9,508	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)		18,657,183		20,704,934	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		0		227,391	6.01	
6.02	SETTLEMENT TO PROGRAM		153,665		0	6.02	
7.00	Total Medicare program liability (see instructions)		18,503,518		20,932,325	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: 140043  
Component CCN: 14U043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/28/2015 8:44 am

Title XVIII Swing Beds - SNF 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		0		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)		0		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet E-1  
Part II  
Date/Time Prepared:  
9/28/2015 8:44 am

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			4,518 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			8,381 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1,042 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			14,347 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			568,331,645 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			5,387,896 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)			443,249 8.00
9.00	Sequestration adjustment amount (see instructions)			8,865 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			434,384 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			434,384 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 140043	Period:	Worksheet E-2
		Component CCN: 14U043	From 05/01/2014 To 04/30/2015	Date/Time Prepared: 9/28/2015 8:44 am
		Title XVIII	Swing Beds - SNF	PPS
			Part A	Part B
			1.00	2.00
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0 1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00 4.00
5.00	Program days		0	0 5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0 6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	0 7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		0	0 10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0 11.00
12.00	Subtotal (line 10 minus line 11)		0	0 12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		0	0 13.00
14.00	80% of Part B costs (line 12 x 80%)			0 14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0 15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0 16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0	0 16.55
17.00	Allowable bad debts (see instructions)		0	0 17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0 17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0 18.00
19.00	Total (see instructions)		0	0 19.00
19.01	Sequestration adjustment (see instructions)		0	0 19.01
20.00	Interim payments		0	0 20.00
21.00	Tentative settlement (for contractor use only)		0	0 21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0 22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2		0	0 23.00

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

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet G

Date/Time Prepared:  
9/28/2015 8:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	28,262,207	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	25,701,568	0	0	0	4.00
5.00	Other receivable	1,106,636	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,109,531	0	0	0	7.00
8.00	Prepaid expenses	2,653,227	0	0	0	8.00
9.00	Other current assets	694,465	0	0	0	9.00
10.00	Due from other funds	6,573,780	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	68,101,414	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,649,399	0	0	0	12.00
13.00	Land improvements	3,968,209	0	0	0	13.00
14.00	Accumulated depreciation	-2,065,309	0	0	0	14.00
15.00	Buildings	88,114,258	0	0	0	15.00
16.00	Accumulated depreciation	-44,698,338	0	0	0	16.00
17.00	Leasehold improvements	13,736,150	0	0	0	17.00
18.00	Accumulated depreciation	-11,542,210	0	0	0	18.00
19.00	Fixed equipment	513,113	0	0	0	19.00
20.00	Accumulated depreciation	-362,087	0	0	0	20.00
21.00	Automobiles and trucks	499,039	0	0	0	21.00
22.00	Accumulated depreciation	-416,308	0	0	0	22.00
23.00	Major movable equipment	65,914,390	0	0	0	23.00
24.00	Accumulated depreciation	-43,782,266	0	0	0	24.00
25.00	Minor equipment depreciable	16,051,600	0	0	0	25.00
26.00	Accumulated depreciation	-10,876,446	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	932,886	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	78,636,080	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	43,746,368	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	5,699,130	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	49,445,498	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	196,182,992	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	4,342,167	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,038,251	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,884,901	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	14,283,966	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	33,549,285	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	23,696,752	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)	23,696,752	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	57,246,037	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	138,936,955				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)	138,936,955	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	196,182,992	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet G-1

Date/Time Prepared:  
9/28/2015 8:44 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		124,359,401		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		14,577,554			2.00
3.00	Total (sum of line 1 and line 2)		138,936,955		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		138,936,955		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		138,936,955		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: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
9/28/2015 8:44 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	32,237,732		32,237,732	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	32,237,732		32,237,732	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,175,811		7,175,811	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)	7,175,811		7,175,811	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,413,543		39,413,543	17.00
18.00	Ancillary services	116,738,922	301,758,519	418,497,441	18.00
19.00	Outpatient services	11,712,587	189,883,466	201,596,053	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,474,821	1,474,821	22.00
23.00	AMBULANCE SERVICES	490	5,289,945	5,290,435	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	10,430,325	30,679,621	41,109,946	27.00
27.01	PT/OT/ST NON-PROVIDER BASED	0	4,140,580	4,140,580	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	178,295,867	533,226,952	711,522,819	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		192,864,020		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	INTEREST EXPENSE	855,909			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)		855,909		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		192,008,111		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140043

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet G-3

Date/Time Prepared:  
9/28/2015 8:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	711,522,819	1.00
2.00	Less contractual allowances and discounts on patients' accounts	511,689,086	2.00
3.00	Net patient revenues (line 1 minus line 2)	199,833,733	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	192,008,111	4.00
5.00	Net income from service to patients (line 3 minus line 4)	7,825,622	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	77,748	6.00
7.00	Income from investments	1,042,659	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	30,985	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	565	13.00
14.00	Revenue from meals sold to employees and guests	796,659	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	75,846	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	23,919	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	231,762	22.00
23.00	Governmental appropriations	600,000	23.00
24.00	INCREASE IN NET EQUITY OF INVESTEES	136,924	24.00
24.01	DAYCARE REVENUE	557,190	24.01
24.02	EHR REVENUE	1,518,994	24.02
24.03	MISCELLANEOUS INCOME	2,534,552	24.03
25.00	Total other income (sum of lines 6-24)	7,627,803	25.00
26.00	Total (line 5 plus line 25)	15,453,425	26.00
27.00	INTEREST EXPENSE	855,909	27.00
27.01	LOSS ON DISPOSAL OF ASSETS	19,962	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	875,871	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,577,554	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140043

Period: From 05/01/2014

Worksheet H

HHA CCN: 147562

To 04/30/2015

Date/Time Prepared: 9/28/2015 8:44 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	94,964	0	22,902	0	139,031	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	692,099	0	0	0	692,099	6.00
7.00	Physical Therapy	139,239	0	0	0	139,239	7.00
8.00	Occupational Therapy	0	0	0	2,123	2,123	8.00
9.00	Speech Pathology	3,463	0	0	6,304	9,767	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	25,165	0	0	0	25,165	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	954,930	0	22,902	8,427	1,125,290	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-57,454	199,443	-391	199,052		5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	692,099	0	692,099		6.00
7.00	Physical Therapy	0	139,239	0	139,239		7.00
8.00	Occupational Therapy	0	2,123	0	2,123		8.00
9.00	Speech Pathology	0	9,767	0	9,767		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	25,165	0	25,165		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
24.00	Total (sum of lines 1-23)	-57,454	1,067,836	-391	1,067,445		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet H-1 Part I Date/Time Prepared: 9/28/2015 8:44 am
		HHA CCN: 147562	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	199,052	0	0	0	199,052	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	692,099	0	0	0	692,099	6.00	
7.00	Physical Therapy	139,239	0	0	0	139,239	7.00	
8.00	Occupational Therapy	2,123	0	0	0	2,123	8.00	
9.00	Speech Pathology	9,767	0	0	0	9,767	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	25,165	0	0	0	25,165	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	1,067,445	0	0	0	1,067,445	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	199,052					5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	158,642	850,741				6.00	
7.00	Physical Therapy	31,916	171,155				7.00	
8.00	Occupational Therapy	487	2,610				8.00	
9.00	Speech Pathology	2,239	12,006				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	5,768	30,933				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		1,067,445				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 140043 HHA CCN: 147562	Period: From 05/01/2014 To 04/30/2015	Worksheet H-1 Part II Date/Time Prepared: 9/28/2015 8:44 am
			Home Health Agency I	PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-199,052	868,393
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	692,099
7.00	Physical Therapy	0	0	0	0	0	139,239
8.00	Occupational Therapy	0	0	0	0	0	2,123
9.00	Speech Pathology	0	0	0	0	0	9,767
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	25,165
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-199,052	868,393
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		199,052
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.229219

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140043

Period: From 05/01/2014

Worksheet H-2

HHA CCN: 147562

To 04/30/2015

Part I  
Date/Time Prepared: 9/28/2015 8:44 am

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
1.00 Administrative and General	0	22,247	26,213	49,400	97,860	24,605	1.00	
2.00 Skilled Nursing Care	850,741	0	0	360,030	1,210,771	304,425	2.00	
3.00 Physical Therapy	171,155	0	0	72,432	243,587	61,245	3.00	
4.00 Occupational Therapy	2,610	0	0	0	2,610	656	4.00	
5.00 Speech Pathology	12,006	0	0	1,801	13,807	3,471	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	30,933	0	0	13,091	44,024	11,069	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	1,067,445	22,247	26,213	496,754	1,612,659	405,471	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.00	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	28,714	0	17,079	0	22,111	47,450	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	28,714	0	17,079	0	22,111	47,450	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140043

Period: From 05/01/2014

Worksheet H-2

HHA CCN: 147562

To 04/30/2015

Part I  
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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	331	0	11,212	249,362	0	249,362	1.00
2.00	Skilled Nursing Care	0	0	0	1,515,196	0	1,515,196	2.00
3.00	Physical Therapy	0	0	0	304,832	0	304,832	3.00
4.00	Occupational Therapy	0	0	0	3,266	0	3,266	4.00
5.00	Speech Pathology	0	0	0	17,278	0	17,278	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	55,093	0	55,093	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	331	0	11,212	2,145,027	0	2,145,027	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	199,313	1,714,509					2.00
3.00	Physical Therapy	40,099	344,931					3.00
4.00	Occupational Therapy	430	3,696					4.00
5.00	Speech Pathology	2,273	19,551					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	7,247	62,340					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	249,362	2,145,027					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.131543						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140043  
HHA CCN: 147562

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet H-2  
Part II  
Date/Time Prepared:  
9/28/2015 8:44 am  
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	2,320	25,905	94,964	0	97,860	2,320	1.00
2.00 Skilled Nursing Care	0	0	692,099	0	1,210,771	0	2.00
3.00 Physical Therapy	0	0	139,239	0	243,587	0	3.00
4.00 Occupational Therapy	0	0	0	0	2,610	0	4.00
5.00 Speech Pathology	0	0	3,463	0	13,807	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	25,165	0	44,024	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	2,320	25,905	954,930		1,612,659	2,320	20.00
21.00 Total cost to be allocated	22,247	26,213	496,754		405,471	28,714	21.00
22.00 Unit cost multiplier	9.589224	1.011890	0.520199		0.251430	12.376724	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	2,320	0	1,511	31,431	4,755	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	2,320	0	1,511	31,431	4,755	20.00
21.00 Total cost to be allocated	0	17,079	0	22,111	47,450	331	21.00
22.00 Unit cost multiplier	0.000000	7.361638	0.000000	14.633355	1.509656	0.069611	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140043  
HHA CCN: 147562

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet H-2  
Part II  
Date/Time Prepared:  
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Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	15.00	16.00		
1.00 Administrative and General	0	1,474,821		1.00
2.00 Skilled Nursing Care	0	0		2.00
3.00 Physical Therapy	0	0		3.00
4.00 Occupational Therapy	0	0		4.00
5.00 Speech Pathology	0	0		5.00
6.00 Medical Social Services	0	0		6.00
7.00 Home Health Aide	0	0		7.00
8.00 Supplies (see instructions)	0	0		8.00
9.00 Drugs	0	0		9.00
10.00 DME	0	0		10.00
11.00 Home Dialysis Aide Services	0	0		11.00
12.00 Respiratory Therapy	0	0		12.00
13.00 Private Duty Nursing	0	0		13.00
14.00 Clinic	0	0		14.00
15.00 Health Promotion Activities	0	0		15.00
16.00 Day Care Program	0	0		16.00
17.00 Home Delivered Meals Program	0	0		17.00
18.00 Homemaker Service	0	0		18.00
19.00 All Others (specify)	0	0		19.00
20.00 Total (sum of lines 1-19)	0	1,474,821		20.00
21.00 Total cost to be allocated	0	11,212		21.00
22.00 Unit cost multiplier	0.000000	0.007602		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet H-3 Part I Date/Time Prepared: 9/28/2015 8:44 am		
				HHA CCN: 147562	Title XVIII		Home Health Agency I	
						PPS		
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,714,509		1,714,509	4,837	354.46	1.00
2.00	Physical Therapy	3.00	344,931	0	344,931	1,631	211.48	2.00
3.00	Occupational Therapy	4.00	3,696	0	3,696	33	112.00	3.00
4.00	Speech Pathology	5.00	19,551	0	19,551	98	199.50	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	62,340		62,340	318	196.04	6.00
7.00	Total (sum of lines 1-6)		2,145,027	0	2,145,027	6,917		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00		4.00		
5.00								
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	1,442			8.00
9.00	Physical Therapy		99914	0	399			9.00
10.00	Occupational Therapy		99914	0	8			10.00
11.00	Speech Pathology		99914	0	21			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	103			13.00
14.00	Total (sum of lines 8-13)			0	1,973			14.00
Ratio (col. 3 ÷ col. 4)								
Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)			
	0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	3,519	3,519	4,361	0.806925	15.00
16.00	Cost of Drugs	9.00	0	52	52	120	0.433333	16.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A			Cost of Services				
	6.00	7.00	8.00	9.00	10.00		11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	1,442		0	511,131		1.00
2.00	Physical Therapy	0	399		0	84,381		2.00
3.00	Occupational Therapy	0	8		0	896		3.00
4.00	Speech Pathology	0	21		0	4,190		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	103		0	20,192		6.00
7.00	Total (sum of lines 1-6)	0	1,973		0	620,790		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	6.00	7.00	8.00	9.00	10.00		11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140043 HHA CCN: 147562	Period: From 05/01/2014 To 04/30/2015	Worksheet H-3 Part I Date/Time Prepared: 9/28/2015 8:44 am	
				Title XVIII	Home Health Agency I	PPS	
Cost Center Description	Program Covered Charges			Cost of Services			
	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00	
<b>Supplies and Drugs Cost Computations</b>							
15.00	Cost of Medical Supplies	0	4,361	0		15.00	
16.00	Cost of Drugs		120	0	52	16.00	
Cost Center Description		Total Program Cost (sum of col.s. 9-10)					
		12.00					
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>							
<b>Cost Per Visit Computation</b>							
1.00	Skilled Nursing Care	511,131					1.00
2.00	Physical Therapy	84,381					2.00
3.00	Occupational Therapy	896					3.00
4.00	Speech Pathology	4,190					4.00
5.00	Medical Social Services	0					5.00
6.00	Home Health Aide	20,192					6.00
7.00	Total (sum of lines 1-6)	620,790					7.00
Cost Center Description							
		12.00					
<b>Limitation Cost Computation</b>							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140043

Period:

Worksheet H-3

HHA CCN: 147562

From 05/01/2014  
To 04/30/2015

Part II  
Date/Time Prepared:  
9/28/2015 8:44 am

Title XVIII

Home Health  
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>							
1.00 Physical Therapy	66.00	0.698512	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.933314	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.609732	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.806875	4,361	3,519	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.429265	120	52	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140043 HHA CCN: 147562	Period: From 05/01/2014 To 04/30/2015	Worksheet H-4 Part I-II Date/Time Prepared: 9/28/2015 8:44 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	52	0
2.00	Total charges	0	120	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	120	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	68	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	52
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	311,547
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	5,220
13.00	Total PPS Reimbursement - LUPA Episodes		0	18,931
14.00	Total PPS Reimbursement - PEP Episodes		0	1,502
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	679
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	337,931
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	337,931
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	337,931
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	337,931
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	337,931
31.01	Sequestration adjustment (see instructions)		0	6,759
32.00	Interim payments (see instructions)		0	331,216
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-44
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2		0	0

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

Provider CCN: 140043  
HHA CCN: 147562

Period:  
From 05/01/2014  
To 04/30/2015

Worksheet H-5  
Date/Time Prepared:  
9/28/2015 8:44 am  
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		0		331,216	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		331,216	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		44	6.02
7.00	Total Medicare program liability (see instructions)		0		331,172	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140043	Period: From 05/01/2014 To 04/30/2015	Worksheet L Parts I-III Date/Time Prepared: 9/28/2015 8:44 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,309,525	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		21,292	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)		39.82	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)		1,330,817	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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