

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 05/01/2015 To 04/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/28/2016 12:10 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 9/28/2016 Time: 12:10 pm	
	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.		
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 05/01/2015 and ending 04/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-231,322	104,001	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-301	0	0	9.00
200.00 Total	0	-231,322	103,700	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140043		Period: From 05/01/2015 To 04/30/2016		Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 10:37 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL Zip Code: 61081-1279		4.00 County: WHITESIDE				
1.00 Street: 100 EAST LEFEVRE ROAD		2.00 City: STERLING								
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		
3.00 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)					05/01/2015	04/30/2016		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 §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1 N			23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,926	532	10	3	19	181		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 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 10:37 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 is in effect in the cost reporting period.	1				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	05/01/2015	04/30/2016			38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06		
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings										
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))					
			1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))				
		1.00	2.00	3.00	4.00	5.00				
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.00	0.000000	65.00

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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		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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		
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)	1.00	2.00	3.00	4.00	5.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					
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.					
85.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N
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.					
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.					N
				V	XIX	
				1.00	2.00	
90.00	Title V and XIX Services 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	
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	
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	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	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	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.				N	110.00
					1.00	
					2.00	
					3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	670,532	0		0	118.01
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 10:37 am		
		1.00	2.00			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:		Zip Code:		143.00
						1.00
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00
				1.00 2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00
		Part A		Part B		Title V
		1.00		2.00		3.00
						Title XIX
						4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N			165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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 §1886(n)? Enter "Y" for yes or "N" for no.		N			167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00			169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/28/2016 10:37 am
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/28/2016 10:37 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 Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/03/2016	Y	08/03/2016
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/28/2016 10:37 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00	2.00	3.00	4.00
		N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSENALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet S-2
Part II
Date/Time Prepared:
9/28/2016 10:37 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
9/28/2016 10:37 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	89	32,574	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)		89	32,574	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	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)		97	35,502	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)		97				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 05/01/2015
To 04/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
9/28/2016 10:37 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)	7,225	1,362	12,628			1.00
2.00 HMO and other (see instructions)	871	535				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)	7,225	1,362	12,628			7.00
8.00 INTENSIVE CARE UNIT	991	154	1,520			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		513	946			13.00
14.00 Total (see instructions)	8,216	2,029	15,094	0.00	1,248.75	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	3,363	0	7,054	0.00	15.37	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	1,264.12	27.00
28.00 Observation Bed Days		0	3,643			28.00
29.00 Ambulance Trips	2,437					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	107	181			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 05/01/2015
To 04/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
9/28/2016 10:37 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
11.00	12.00	13.00	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,178	639	4,648	1.00
2.00 HMO and other (see instructions)			249	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,178	639	4,648	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 05/01/2015
To 04/30/2016

Worksheet S-3
Part II
Date/Time Prepared:
9/28/2016 10:37 am

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	88,887,216	0	88,887,216	2,725,078.35	32.62
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		2,042,802	0	2,042,802	14,633.79	139.59
4.00	Physician-Part A - Administrative		152,761	0	152,761	1,018.33	150.01
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		28,142,972	0	28,142,972	176,737.00	159.24
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		7,281,072	102,152	7,383,224	250,949.74	29.42
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		620,623	0	620,623	17,651.50	35.16
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		5,650	0	5,650	37.67	149.99
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		24,398,437	0	24,398,437		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		2,902,221	0	2,902,221		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		372,023	0	372,023		
22.00	Physician Part A - Administrative		27,034	0	27,034		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		4,868,127	0	4,868,127		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	417,641	0	417,641	13,083.07	31.92
27.00	Administrative & General	5.00	11,508,281	-15,447	11,492,834	435,048.51	26.42
28.00	Administrative & General under contract (see inst.)		82,113	0	82,113	477.88	171.83
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	1,089,228	0	1,089,228	45,772.28	23.80
31.00	Laundry & Linen Service	8.00	253,097	0	253,097	22,535.61	11.23
32.00	Housekeeping	9.00	981,280	0	981,280	76,050.46	12.90
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	888,711	-669,359	219,352	15,623.55	14.04
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	669,359	669,359	47,675.00	14.04
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,178,579	-326,562	852,017	21,762.15	39.15
39.00	Central Services and Supply	14.00	393,160	0	393,160	21,411.27	18.36
40.00	Pharmacy	15.00	1,085,480	-1,085,480	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet S-3
Part II
Date/Time Prepared:
9/28/2016 10:37 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	1,643,396	0	1,643,396	84,920.46	19.35	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 05/01/2015
To 04/30/2016

Worksheet S-3
Part III
Date/Time Prepared:
9/28/2016 10:37 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	58,783,555	0	58,783,555	2,534,185.44	23.20	1.00
2.00	Excluded area salaries (see instructions)	7,281,072	102,152	7,383,224	250,949.74	29.42	2.00
3.00	Subtotal salaries (line 1 minus line 2)	51,502,483	-102,152	51,400,331	2,283,235.70	22.51	3.00
4.00	Subtotal other wages & related costs (see inst.)	626,273	0	626,273	17,689.17	35.40	4.00
5.00	Subtotal wage-related costs (see inst.)	24,425,471	0	24,425,471	0.00	47.52	5.00
6.00	Total (sum of lines 3 thru 5)	76,554,227	-102,152	76,452,075	2,300,924.87	33.23	6.00
7.00	Total overhead cost (see instructions)	19,520,966	-1,427,489	18,093,477	784,360.24	23.07	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 9/28/2016 10:37 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,218,651	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)	4,728,578	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	18,420,661	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)	108,841	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	234,033	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	42,513	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,086,108	17.00
18.00	Medicare Taxes - Employers Portion Only	1,271,935	18.00
19.00	Unemployment Insurance	33,667	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	422,946	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	32,567,933	24.00
Part B - Other than Core Related Cost			
25.00		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet S-3
Part V
Date/Time Prepared:
9/28/2016 10:37 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	647,671	0	1.00
2.00	Hospital	625,235	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	22,436	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 05/01/2015 To 04/30/2016		Worksheet S-4 Date/Time Prepared: 9/28/2016 10:37 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	355	0	1,750	2,105	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	313.00	43.00	238.00	594.00	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		1.95	0.00	1.95	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			10.66	0.00	10.66	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.76	0.10	1.86	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.02	0.02	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.97	0.00	0.97	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	1,732	21	166	67	1,986	21.00
22.00	Skilled Nursing Visit Charges	337,608	4,095	32,151	13,065	386,919	22.00
23.00	Physical Therapy Visits	985	0	43	5	1,033	23.00
24.00	Physical Therapy Visit Charges	180,255	0	6,405	915	187,575	24.00
25.00	Occupational Therapy Visits	17	0	1	0	18	25.00
26.00	Occupational Therapy Visit Charges	2,975	0	175	0	3,150	26.00
27.00	Speech Pathology Visits	2	0	0	0	2	27.00
28.00	Speech Pathology Visit Charges	370	0	0	0	370	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	307	17	0	0	324	31.00
32.00	Home Health Aide Visit Charges	26,095	1,445	0	0	27,540	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,043	38	210	72	3,363	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)	547,303	5,540	38,731	13,980	605,554	35.00
36.00	Total Number of Episodes (standard/non outlier)	286		75	9	370	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	10,725	993	2,742	827	15,287	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet S-10 Date/Time Prepared: 9/28/2016 10:37 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.227833	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,583,472	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		7,233,492	5.00	
6.00	Medicaid charges		91,690,758	6.00	
7.00	Medicaid cost (line 1 times line 6)		20,890,180	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)		6,073,216	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		132,276	9.00	
10.00	Stand-alone SCHIP charges		919,142	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		209,411	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		77,135	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)		6,150,351	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,451,576	958,569	4,410,145	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	786,383	218,394	1,004,777	21.00
22.00	Partial payment by patients approved for charity care	299,914	0	299,914	22.00
23.00	Cost of charity care (line 21 minus line 22)	486,469	218,394	704,863	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		8,803,032	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,046,400	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		7,756,632	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,767,217	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,472,080	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,622,431	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet A	
Date/Time Prepared: 9/28/2016 10:37 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		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT		12,040,841	12,040,841	-4,924,188	7,116,653	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0	0	7,966,528	7,966,528	2.00
3.00 00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	417,641	32,155,986	32,573,627	-1,737	32,571,890	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	11,508,281	11,604,705	23,112,986	428,727	23,541,713	5.00
7.00 00700	OPERATION OF PLANT	1,089,228	2,432,668	3,521,896	-64,391	3,457,505	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	253,097	152,761	405,858	0	405,858	8.00
9.00 00900	HOUSEKEEPING	981,280	1,172,995	2,154,275	-8,371	2,145,904	9.00
10.00 01000	DIETARY	888,711	978,815	1,867,526	-1,406,582	460,944	10.00
11.00 01100	CAFETERIA	0	0	0	1,406,582	1,406,582	11.00
13.00 01300	NURSING ADMINISTRATION	1,178,579	106,877	1,285,456	-331,433	954,023	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	393,160	286,754	679,914	-188,200	491,714	14.00
15.00 01500	PHARMACY	1,085,480	5,942,728	7,028,208	-6,712,187	316,021	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,643,396	807,110	2,450,506	0	2,450,506	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	10,074,180	849,905	10,924,085	-648,678	10,275,407	30.00
31.00 03100	INTENSIVE CARE UNIT	2,007,247	378,053	2,385,300	-828,153	1,557,147	31.00
43.00 04300	NURSERY	0	0	0	458,936	458,936	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,458,893	5,053,234	6,512,127	-4,710,616	1,801,511	50.00
51.00 05100	RECOVERY ROOM	730,029	261,119	991,148	-219,077	772,071	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	818,469	818,469	52.00
53.00 05300	ANESTHESIOLOGY	2,042,802	565,727	2,608,529	-416,476	2,192,053	53.00
53.01 05301	PAIN MANAGEMENT	902,935	83,264	986,199	-59,808	926,391	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,132,928	1,922,900	3,055,828	288,416	3,344,244	54.00
54.01 05401	ULTRASOUND	424,936	602,314	1,027,250	77,577	1,104,827	54.01
56.00 05600	RADIOISOTOPE	237,292	1,154,794	1,392,086	-961,241	430,845	56.00
57.00 05700	CT SCAN	515,046	1,904,210	2,419,256	-53,481	2,365,775	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	336,783	796,298	1,133,081	9,359	1,142,440	58.00
59.00 05900	CARDIAC CATHETERIZATION	791,027	2,112,998	2,904,025	-1,866,288	1,037,737	59.00
60.00 06000	LABORATORY	2,694,722	4,068,200	6,762,922	-1,555,697	5,207,225	60.00
65.00 06500	RESPIRATORY THERAPY	842,415	270,405	1,112,820	-152,954	959,866	65.00
66.00 06600	PHYSICAL THERAPY	302,527	12,946	315,473	-5,279	310,194	66.00
67.00 06700	OCCUPATIONAL THERAPY	71,301	5,319	76,620	-3,241	73,379	67.00
68.00 06800	SPEECH PATHOLOGY	97,088	2,139	99,227	-35	99,192	68.00
69.00 06900	ELECTROCARDIOLOGY	765,981	231,582	997,563	-77,264	920,299	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	240,325	100,186	340,511	-19,368	321,143	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,922,459	12,922,459	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	17,792,078	17,792,078	73.00
74.00 07400	RENAL DIALYSIS	0	100,359	100,359	-831	99,528	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01 07501	GI LAB	894,888	828,633	1,723,521	-685,907	1,037,614	75.01
76.00 03950	DIABETIC EDUCATION	180,856	165,307	346,163	-22,264	323,899	76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	477,681	728,423	1,206,104	-253,684	952,420	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	31,726,585	14,323,033	46,049,618	-12,528,008	33,521,610	90.00
91.00 09100	EMERGENCY	3,218,824	5,524,575	8,743,399	-451,780	8,291,619	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	1,528,990	294,952	1,823,942	-115,153	1,708,789	95.00
98.00 09850	HOME INFUSION	65,026	137,837	202,863	-19,027	183,836	98.00
101.00 10100	HOME HEALTH AGENCY	977,691	140,553	1,118,244	-41,150	1,077,094	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE		603,995	603,995	-603,995	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	84,177,851	110,905,500	195,083,351	2,232,587	197,315,938	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,843	34,557	55,400	0	55,400	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,434,687	957,832	4,392,519	-11,834	4,380,685	192.00
194.00 07950	COMMUNITY SERVICE	243,588	98,768	342,356	101,899	444,255	194.00
194.01 07951	OFFSITE FREESTANDING PT/OT	1,010,247	64,103	1,074,350	0	1,074,350	194.01
194.02 07952	OFFSITE BUILDINGS	0	2,450,947	2,450,947	-2,322,652	128,295	194.02
200.00	TOTAL (SUM OF LINES 118-199)	88,887,216	114,511,707	203,398,923	0	203,398,923	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet A
Date/Time Prepared:
9/28/2016 10:37 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-603,995	6,512,658	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-10,892	7,955,636	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,222,419	28,349,471	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,635,590	20,906,123	5.00
7.00	00700	OPERATION OF PLANT	-4,654	3,452,851	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	405,858	8.00
9.00	00900	HOUSEKEEPING	-158	2,145,746	9.00
10.00	01000	DIETARY	-8,169	452,775	10.00
11.00	01100	CAFETERIA	-793,907	612,675	11.00
13.00	01300	NURSING ADMINISTRATION	0	954,023	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	491,714	14.00
15.00	01500	PHARMACY	0	316,021	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-90,649	2,359,857	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,473,544	7,801,863	30.00
31.00	03100	INTENSIVE CARE UNIT	-19,111	1,538,036	31.00
43.00	04300	NURSERY	0	458,936	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,801,511	50.00
51.00	05100	RECOVERY ROOM	0	772,071	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	818,469	52.00
53.00	05300	ANESTHESIOLOGY	-2,139,489	52,564	53.00
53.01	05301	PAIN MANAGEMENT	-685,846	240,545	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,361,407	1,982,837	54.00
54.01	05401	ULTRASOUND	-483,357	621,470	54.01
56.00	05600	RADIOISOTOPE	-56,855	373,990	56.00
57.00	05700	CT SCAN	-1,629,272	736,503	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-596,350	546,090	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,037,737	59.00
60.00	06000	LABORATORY	-546,032	4,661,193	60.00
65.00	06500	RESPIRATORY THERAPY	-3,568	956,298	65.00
66.00	06600	PHYSICAL THERAPY	0	310,194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	73,379	67.00
68.00	06800	SPEECH PATHOLOGY	0	99,192	68.00
69.00	06900	ELECTROCARDIOLOGY	-18,329	901,970	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	321,143	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,922,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-945,407	16,846,671	73.00
74.00	07400	RENAL DIALYSIS	0	99,528	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	GI LAB	0	1,037,614	75.01
76.00	03950	DIABETIC EDUCATION	0	323,899	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	-349,248	603,172	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-26,448,657	7,072,953	90.00
91.00	09100	EMERGENCY	-4,916,722	3,374,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	140	1,708,929	95.00
98.00	09850	HOME INFUSION	-2,600	181,236	98.00
101.00	10100	HOME HEALTH AGENCY	-1,567	1,075,527	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-51,047,654	146,268,284	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	55,400	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,380,685	192.00
194.00	07950	COMMUNITY SERVICE	0	444,255	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	0	1,074,350	194.01
194.02	07952	OFFSITE BUILDINGS	0	128,295	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-51,047,654	152,351,269	200.00

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	603,995	1.00
	O		0	603,995	
B - TO RECLASS L&D AND NURSERY COST					
1.00	NURSERY	43.00	426,545	21,435	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	760,701	38,228	2.00
	O		1,187,246	59,663	
C - TO RECLASS OFFSITE BLDG					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	189,436	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,714,761	2.00
3.00	OTHER CAP REL COSTS	3.00	0	18,915	3.00
4.00	OPERATION OF PLANT	7.00	0	412,300	4.00
5.00	OFFSITE BUILDINGS	194.02	0	4,513	5.00
6.00	OFFSITE BUILDINGS	194.02	0	8,247	6.00
	O		0	2,348,172	
D - TO RECLASS PHYSICIAN REMUNERATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	15,000	0	1.00
	O		15,000	0	
E - TO RECLASS COLL AND BILLING EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,663	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	O		0	45,663	
G - TO RECLASS CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	669,359	737,223	1.00
	O		669,359	737,223	
H - TO RECLASS DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,085,480	16,706,598	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
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	O		1,085,480	16,706,598	
I - TO RECLASS MARKETING AND ADV					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,615	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	O		0	16,615	
J - TO RECLASS TELEPHONE EXPENSE					
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
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00

RECLASSIFICATIONS

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
15.00		0.00	0	0	15.00
			0	135,109	
K - TO RECLASS PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	341,314	1.00
2.00	OTHER CAP REL COSTS	3.00	0	178,432	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
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
			0	519,746	
L - TO RECLASS MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,200	1.00
			0	17,200	
M - TO RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,922,459	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	12,922,459	
N - TO RECLASS POPULATION HLTH MGMT					
1.00	ADMINISTRATIVE & GENERAL	5.00	521,304	286,623	1.00
3.00	COMMUNITY SERVICE	194.00	102,152	6,076	3.00
			623,456	292,699	
O - TO RECLASS POST ICU					
1.00	ADULTS & PEDIATRICS	30.00	676,379	83,704	1.00
			676,379	83,704	
P - TO RECLASS MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,879,654	1.00
			0	7,879,654	
Q - TO RECLASS UTILITIES EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	4,711	1.00
			0	4,711	
R - TO RECLASS NURSING FLOATS					
1.00	ADULTS & PEDIATRICS	30.00	253,598	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	42,468	0	2.00
3.00	NURSERY	43.00	10,956	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	19,540	0	4.00
			326,562	0	
S - TO RECLASS RADIOLOGY MANAGEMENT					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	282,814	24,344	1.00
2.00	ULTRASOUND	54.01	73,470	6,324	2.00
3.00	RADIOISOTOPE	56.00	39,714	3,418	3.00
4.00	CT SCAN	57.00	101,580	8,744	4.00

RECLASSIFICATIONS

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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	54,173	4,663	5.00
			551,751	47,493	
T - TO RECLASS RADIOLOGY TECHS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	37,364	0	1.00
2.00	ULTRASOUND	54.01	14,209	0	2.00
3.00	CT SCAN	57.00	8,054	0	3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	1,076	0	4.00
			60,703	0	
500.00	Grand Total: Increases		5,195,936	42,420,704	500.00

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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - TO RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	603,995	11		1.00
	O		0	603,995			
B - TO RECLASS L&D AND NURSERY COST							
1.00	ADULTS & PEDIATRICS	30.00	1,187,246	59,663	0		1.00
2.00	O	0.00	0	0	0		2.00
			1,187,246	59,663			
C - TO RECLASS OFFSITE BLDG							
1.00	HOUSEKEEPING	9.00	0	8,247	13		1.00
2.00	OFFSITE BUILDINGS	194.02	0	2,335,412	10		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,513	9		3.00
4.00	O	0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
			0	2,348,172			
D - TO RECLASS PHYSICIAN REMUNERATION							
1.00	CLINIC	90.00	15,000	0	0		1.00
	O		15,000	0			
E - TO RECLASS COLL AND BILLING EXP							
1.00	AMBULANCE SERVICES	95.00	0	45,150	0		1.00
2.00	HOME INFUSION	98.00	0	44	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	469	0		3.00
	O		0	45,663			
G - TO RECLASS CAFETERIA EXPENSE							
1.00	DIETARY	10.00	669,359	737,223	0		1.00
	O		669,359	737,223			
H - TO RECLASS DRUG EXPENSE							
1.00	NURSING ADMINISTRATION	13.00	0	474	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	91	0		2.00
3.00	PHARMACY	15.00	1,085,480	5,542,271	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	7,175	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	2,386	0		5.00
6.00	RECOVERY ROOM	51.00	0	34,426	0		6.00
7.00	ANESTHESIOLOGY	53.00	0	219,499	0		7.00
8.00	PAIN MANAGEMENT	53.01	0	1,698	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,853	0		9.00
10.00	RADIOISOTOPE	56.00	0	326,533	0		10.00
11.00	CT SCAN	57.00	0	67	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	4	0		12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	13,057	0		13.00
14.00	LABORATORY	60.00	0	1,375	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	1,831	0		15.00
17.00	ELECTROCARDIOLOGY	69.00	0	122	0		17.00
18.00	GI LAB	75.01	0	1,449	0		18.00
20.00	HYPERBARIC OXYGEN THERAPY	76.98	0	11,214	0		20.00
21.00	CLINIC	90.00	0	10,525,271	0		21.00
22.00	EMERGENCY	91.00	0	9,490	0		22.00
23.00	AMBULANCE SERVICES	95.00	0	6,312	0		23.00
	O		1,085,480	16,706,598			
I - TO RECLASS MARKETING AND ADV							
1.00	NURSING ADMINISTRATION	13.00	0	4,397	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,215	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,065	0		3.00
5.00	HYPERBARIC OXYGEN THERAPY	76.98	0	825	0		5.00
6.00	CLINIC	90.00	0	1,300	0		6.00
7.00	EMERGENCY	91.00	0	1,523	0		7.00
9.00	HOME HEALTH AGENCY	101.00	0	374	0		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,916	0		10.00
	O		0	16,615			
J - TO RECLASS TELEPHONE EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	1,243	0		1.00
2.00	PHARMACY	15.00	0	495	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	9,359	0		3.00
4.00	OPERATING ROOM	50.00	0	4,222	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	9,111	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	379	0		6.00
7.00	RADIOISOTOPE	56.00	0	74	0		7.00
8.00	LABORATORY	60.00	0	1,706	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	242	0		9.00
10.00	CLINIC	90.00	0	81,105	0		10.00
11.00	EMERGENCY	91.00	0	457	0		11.00
12.00	AMBULANCE SERVICES	95.00	0	9,978	0		12.00
13.00	HOME HEALTH AGENCY	101.00	0	5,189	0		13.00

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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	8,918	0		14.00
15.00	COMMUNITY SERVICE	194.00	0	2,631	0		15.00
	0		0	135,109			
K - TO RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,543	13		1.00
2.00	OPERATION OF PLANT	7.00	0	341,314	0		2.00
3.00	OPERATION OF PLANT	7.00	0	138,845	0		3.00
4.00	HOUSEKEEPING	9.00	0	124	0		4.00
7.00	AMBULANCE SERVICES	95.00	0	10,769	0		7.00
8.00	HOME INFUSION	98.00	0	1,394	0		8.00
9.00	HOME HEALTH AGENCY	101.00	0	14,059	0		9.00
10.00	COMMUNITY SERVICE	194.00	0	3,698	0		10.00
	0		0	519,746			
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	1,737	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	188,109	0		2.00
3.00	PHARMACY	15.00	0	83,941	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	397,701	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	108,152	0		5.00
6.00	OPERATING ROOM	50.00	0	4,706,394	0		6.00
7.00	RECOVERY ROOM	51.00	0	184,651	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	187,866	0		8.00
9.00	PAIN MANAGEMENT	53.01	0	58,110	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	49,809	0		10.00
11.00	ULTRASOUND	54.01	0	16,426	0		11.00
12.00	RADIOISOTOPE	56.00	0	677,766	0		12.00
13.00	CT SCAN	57.00	0	171,792	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	50,549	0		14.00
15.00	CARDIAC CATHETERIZATION	59.00	0	1,853,231	0		15.00
16.00	LABORATORY	60.00	0	1,552,616	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	151,123	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	5,279	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	3,241	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	35	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	76,900	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	19,368	0		22.00
23.00	RENAL DIALYSIS	74.00	0	831	0		23.00
24.00	GI LAB	75.01	0	684,458	0		24.00
25.00	DIABETIC EDUCATION	76.00	0	22,264	0		25.00
26.00	HYPERBARIC OXYGEN THERAPY	76.98	0	241,645	0		26.00
27.00	CLINIC	90.00	0	928,474	0		27.00
28.00	EMERGENCY	91.00	0	440,310	0		28.00
29.00	AMBULANCE SERVICES	95.00	0	21,033	0		29.00
30.00	HOME INFUSION	98.00	0	17,589	0		30.00
31.00	HOME HEALTH AGENCY	101.00	0	21,059	0		31.00
	0		0	12,922,459			
N - TO RECLASS POPULATION HLTH MGMT							
1.00	CLINIC	90.00	623,456	292,699	0		1.00
3.00		0.00	0	0	0		3.00
	0		623,456	292,699			
O - TO RECLASS POST ICU							
1.00	INTENSIVE CARE UNIT	31.00	676,379	83,704	0		1.00
	0		676,379	83,704			
P - TO RECLASS MME DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,879,654	9		1.00
	0		0	7,879,654			
Q - TO RECLASS UTILITIES EXPENSE							
1.00	AMBULANCE SERVICES	95.00	0	4,711	0		1.00
	0		0	4,711			
R - TO RECLASS NURSING FLOATS							
1.00	NURSING ADMINISTRATION	13.00	326,562	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		326,562	0			
S - TO RECLASS RADIOLOGY MANAGEMENT							
1.00	ADMINISTRATIVE & GENERAL	5.00	551,751	47,493	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

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet A-6

Date/Time Prepared:
9/28/2016 10:37 am

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
5.00	0.00	0	0	0	0	0	5.00
		551,751	47,493				
T - TO RECLASS RADIOLOGY TECHS							
1.00	90.00	60,703	0	0	0	0	1.00
2.00	0.00	0	0	0	0	0	2.00
3.00	0.00	0	0	0	0	0	3.00
4.00	0.00	0	0	0	0	0	4.00
	0	60,703	0	0	0	0	
500.00	Grand Total: Decreases		5,195,936	42,420,704			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet A-7
Part I
Date/Time Prepared:
9/28/2016 10:37 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,649,399	0	0	0	1.00
2.00	Land Improvements	3,968,209	136,444	0	136,444	2.00
3.00	Buildings and Fixtures	88,114,258	1,256,610	0	1,256,610	3.00
4.00	Building Improvements	13,736,150	0	0	0	4.00
5.00	Fixed Equipment	513,113	46,747	0	46,747	5.00
6.00	Movable Equipment	82,465,029	6,857,607	0	6,857,607	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	191,446,158	8,297,408	0	8,297,408	8.00
9.00	Reconciling Items	-932,886	-7,918,268	0	-7,918,268	9.00
10.00	Total (line 8 minus line 9)	192,379,044	16,215,676	0	16,215,676	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,649,399	0			1.00
2.00	Land Improvements	4,104,653	0			2.00
3.00	Buildings and Fixtures	89,348,793	0			3.00
4.00	Building Improvements	13,733,621	0			4.00
5.00	Fixed Equipment	509,585	0			5.00
6.00	Movable Equipment	85,862,849	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	196,208,900	0			8.00
9.00	Reconciling Items	-553,746	0			9.00
10.00	Total (line 8 minus line 9)	196,762,646	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet A-7
Part II
Date/Time Prepared:
9/28/2016 10:37 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	12,040,841	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)	12,040,841	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	12,040,841				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	12,040,841				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet A-7
Part III
Date/Time Prepared:
9/28/2016 10:37 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	109,836,466	0	109,836,466	0.559793	110,473	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	86,372,434	0	86,372,434	0.440207	86,874	2.00
3.00	Total (sum of lines 1-2)	196,208,900	0	196,208,900	1.000000	197,347	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	110,473	4,156,674	1,714,761	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	86,874	7,868,762	0	2.00
3.00	Total (sum of lines 1-2)	0	0	197,347	12,025,436	1,714,761	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	110,473	530,750	0	6,512,658	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	86,874	0	0	7,955,636	2.00
3.00	Total (sum of lines 1-2)	0	197,347	530,750	0	14,468,294	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet A-8

Date/Time Prepared:
9/28/2016 10:37 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	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-603,995	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	-31,669	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)		0			0.00	0 7.00
8.00 Television and radio service (chapter 21)		0			0.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-39,610,438				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	-792,613	CAFETERIA		11.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients	B	-945,407	DRUGS CHARGED TO PATIENTS		73.00	0 17.00
18.00 Sale of medical records and abstracts	B	-90,649	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	-1,294	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	-8,169	DIETARY		10.00	0 33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet A-8

Date/Time Prepared:
9/28/2016 10:37 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	
33.02	RENTAL INCOME	B	-4,293	OPERATION OF PLANT	7.00	0	33.02
33.03			0		0.00	0	33.03
33.04	MI SCCELLANEOUS INCOME - A&G	B	-80,646	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MI SCCELLANEOUS INCOME - RT	B	-3,568	RESPIRATORY THERAPY	65.00	0	33.05
33.06	MI SCCELLANEOUS INCOME - RADIOLOGY	B	-667	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	MI SCCELLANEOUS INCOME - AMBULANCE	B	140	AMBULANCE SERVICES	95.00	0	33.07
33.08	MI SCCELLANEOUS INCOME - PLANT	B	-361	OPERATION OF PLANT	7.00	0	33.08
33.09	MI SCCELLANEOUS INCOME - A&P	B	-21	ADULTS & PEDIATRICS	30.00	0	33.09
33.10	HOME NURSING INCOME	B	-1,567	HOME HEALTH AGENCY	101.00	0	33.10
33.11	CARDIAC REHAB PHASE III REVENUE	B	-18,329	ELECTROCARDIOLOGY	69.00	0	33.11
33.12	MI SCCELLANEOUS INCOME - CAT SCAN	B	-3,660	CT SCAN	57.00	0	33.12
33.13	BLOOD DRAW INCOME	B	-2,600	HOME INFUSION	98.00	0	33.13
33.14	HOUSEKEEPING REVENUE	B	-158	HOUSEKEEPING	9.00	0	33.14
33.15	PATIENT ACCOUNTING REVENUE	B	-45,225	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	DAYCARE REVENUE	B	-503,419	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	DAYCARE DISCOUNT EXPENSE ELIMINATION	A	-34,908	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
34.00	DONATION EXPENSE - A&G	A	-331,504	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	LOBBYING EXPENSE	A	-47,341	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PHYSICIAN RECRUITMENT SALARIES	A	-82,419	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01	PHYSICIAN RECRUITMENT OTHER EXPENSES	A	-531,949	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	PHYSICIAN RECRUITMENT BENEFITS	A	-34,980	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.02
36.03	PHYSICIAN RECRUITMENT	A	-400	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.03
37.00	MARKETING SALARIES	A	-234,978	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	MARKETING OTHER EXPENSES	A	-626,257	ADMINISTRATIVE & GENERAL	5.00	0	37.01
37.02	MARKETING DEPRECIATION	A	-10,492	CAP REL COSTS-MVBLE EQUIP	2.00	9	37.02
37.03	MARKETING BENEFITS	A	-90,183	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.03
38.00	CABLE TELEVISION	A	-43,497	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	CABLE TELEVISION	A	-2,649	CLINIC	90.00	0	38.01
39.00	CRNA SALARIES	A	-2,042,802	ANESTHESIOLOGY	53.00	0	39.00
39.01	CRNA LOCUM TENENS	A	-48,009	ANESTHESIOLOGY	53.00	0	39.01
39.02	CRNA MALPRACTICE INSURANCE	A	-32,567	ANESTHESIOLOGY	53.00	0	39.02
39.03	CRNA PHYSICIAN CME EXPENSE	A	-16,111	ANESTHESIOLOGY	53.00	0	39.03
39.04	CRNA FICA TAXES	A	-51,648	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.04
39.05	CRNA MEDICARE TAXES	A	-29,270	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.05
39.06	CRNA BENEFITS	A	-299,048	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.06
40.00	ALCOHOLIC BEVERAGE EXPENSE	A	-7,652	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	PHYSICIAN BENEFITS	A	-3,682,382	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-51,047,654				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 05/01/2015
To 04/30/2016

Worksheet A-8-2

Date/Time Prepared:
9/28/2016 10:37 am

1.00	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	ADMINISTRATIVE & GENERAL	158,411	0	158,411	211,500	1,056	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,473,523	2,473,523	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	19,111	19,111	0	0	0	3.00
4.00	53.01	PAIN MANAGEMENT	685,846	685,846	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,360,740	1,360,740	0	0	0	5.00
6.00	54.01	ULTRASOUND	483,357	483,357	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	56,855	56,855	0	0	0	7.00
8.00	57.00	CT SCAN	1,625,612	1,625,612	0	0	0	8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	596,350	596,350	0	0	0	9.00
10.00	60.00	LABORATORY	546,032	546,032	0	0	0	10.00
11.00	76.98	HYPERBARIC OXYGEN THERAPY	349,248	349,248	0	0	0	11.00
12.00	90.00	CLINIC	26,446,008	26,446,008	0	0	0	12.00
13.00	91.00	EMERGENCY	4,916,722	4,916,722	0	0	0	13.00
200.00			39,717,815	39,559,404	158,411		1,056	200.00
1.00	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	ADMINISTRATIVE & GENERAL	107,377	5,369	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	22,123	0	97,819	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	19,111	3.00
4.00	53.01	PAIN MANAGEMENT	0	0	0	0	6,302	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	54.01	ULTRASOUND	0	0	0	0	0	6.00
7.00	56.00	RADIOISOTOPE	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	0	0	9,939	0	34,498	10.00
11.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	2,685	11.00
12.00	90.00	CLINIC	0	0	219,034	0	885,010	12.00
13.00	91.00	EMERGENCY	0	0	0	0	0	13.00
200.00			107,377	5,369	251,096	0	1,045,425	200.00
1.00	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	ADMINISTRATIVE & GENERAL	0	107,377	51,034	51,034		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,473,523		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	19,111		3.00
4.00	53.01	PAIN MANAGEMENT	0	0	0	685,846		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,360,740		5.00
6.00	54.01	ULTRASOUND	0	0	0	483,357		6.00
7.00	56.00	RADIOISOTOPE	0	0	0	56,855		7.00
8.00	57.00	CT SCAN	0	0	0	1,625,612		8.00
9.00	58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	596,350		9.00
10.00	60.00	LABORATORY	0	0	0	546,032		10.00
11.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	349,248		11.00
12.00	90.00	CLINIC	0	0	0	26,446,008		12.00
13.00	91.00	EMERGENCY	0	0	0	4,916,722		13.00
200.00			0	107,377	51,034	39,610,438		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet B
Part I
Date/Time Prepared:
9/28/2016 10:37 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,512,658	6,512,658			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	7,955,636		7,955,636		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	28,349,471	12,396	4,635	28,366,502	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,906,123	1,107,695	2,195,787	5,448,662	5.00
7.00 00700	OPERATION OF PLANT	3,452,851	210,542	19,472	533,495	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	405,858	80,939	20,964	123,965	8.00
9.00 00900	HOUSEKEEPING	2,145,746	8,416	17,892	480,623	9.00
10.00 01000	DIETARY	452,775	25,964	24,456	107,437	10.00
11.00 01100	CAFETERIA	612,675	79,233	74,636	327,847	11.00
13.00 01300	NURSING ADMINISTRATION	954,023	2,456	44,321	417,311	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	491,714	11,884	39,931	192,567	14.00
15.00 01500	PHARMACY	316,021	24,155	108,122	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,359,857	60,855	71,132	804,922	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,801,863	537,380	400,491	3,666,558	30.00
31.00 03100	INTENSIVE CARE UNIT	1,538,036	115,614	108,247	672,649	31.00
43.00 04300	NURSERY	458,936	98,032	49,519	214,284	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,801,511	276,901	681,788	714,554	50.00
51.00 05100	RECOVERY ROOM	772,071	151,347	66,343	357,562	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	818,469	115,728	88,274	382,156	52.00
53.00 05300	ANESTHESIOLOGY	52,564	7,278	5,051	0	53.00
53.01 05301	PAIN MANAGEMENT	240,545	34,118	8,744	109,415	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,982,837	196,474	727,818	711,720	54.00
54.01 05401	ULTRASOUND	621,470	33,219	81,572	251,075	54.01
56.00 05600	RADIOISOTOPE	373,990	78,312	164,550	135,675	56.00
57.00 05700	CT SCAN	736,503	21,517	130,517	305,963	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	546,090	45,684	49,583	192,014	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,037,737	89,389	604,833	387,439	59.00
60.00 06000	LABORATORY	4,661,193	138,416	300,207	1,131,266	60.00
65.00 06500	RESPIRATORY THERAPY	956,298	59,297	84,515	412,608	65.00
66.00 06600	PHYSICAL THERAPY	310,194	10,577	4,352	148,175	66.00
67.00 06700	OCCUPATIONAL THERAPY	73,379	4,560	0	34,923	67.00
68.00 06800	SPEECH PATHOLOGY	99,192	1,365	0	47,553	68.00
69.00 06900	ELECTROCARDIOLOGY	901,970	46,264	116,365	375,171	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	321,143	14,910	23,162	117,709	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,922,459	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	16,846,671	0	0	531,659	73.00
74.00 07400	RENAL DIALYSIS	99,528	2,275	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	GI LAB	1,037,614	40,020	242,263	438,309	75.01
76.00 03950	DIABETIC EDUCATION	323,899	17,684	3,366	88,582	76.00
76.98 07698	HYPERBARI C OXYGEN THERAPY	603,172	29,739	16,901	135,091	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	7,072,953	1,898,325	492,726	3,174,765	90.00
91.00 09100	EMERGENCY	3,374,897	237,233	744,985	1,576,554	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	1,708,929	35,915	75,295	748,887	95.00
98.00 09850	HOME INFUSION	181,236	2,388	0	31,849	98.00
101.00 10100	HOME HEALTH AGENCY	1,075,527	26,385	35,379	478,865	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	146,268,284	5,990,881	7,928,194	26,009,859	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	55,400	14,409	2,557	10,209	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	4,380,685	383,520	24,763	1,682,282	192.00
194.00 07950	COMMUNITY SERVICE	444,255	36,563	122	169,341	194.00
194.01 07951	OFFSITE FREESTANDING PT/OT	1,074,350	87,285	0	494,811	194.01
194.02 07952	OFFSITE BUILDINGS	128,295	0	0	0	194.02
200.00 200.00	Cross Foot Adjustments					200.00
201.00 201.00	Negative Cost Centers					201.00
202.00 202.00	TOTAL (sum lines 118-201)	152,351,269	6,512,658	7,955,636	28,366,502	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part I Date/Time Prepared: 9/28/2016 10:37 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	29,658,267				5.00
7.00	00700	OPERATION OF PLANT	1,019,208	5,235,568			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	152,705	81,775	866,206		8.00
9.00	00900	HOUSEKEEPING	641,224	8,503	69,170	3,371,574	9.00
10.00	01000	DIETARY	147,606	26,232	3,804	17,189	805,463
11.00	01100	CAFETERIA	264,544	80,052	11,611	52,456	0
13.00	01300	NURSING ADMINISTRATION	342,796	2,482	0	1,626	0
14.00	01400	CENTRAL SERVICES & SUPPLY	177,934	12,007	0	7,868	0
15.00	01500	PHARMACY	108,366	24,405	0	15,992	0
16.00	01600	MEDICAL RECORDS & LIBRARY	796,917	61,484	0	40,289	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,998,936	542,933	343,756	355,770	725,375
31.00	03100	INTENSIVE CARE UNIT	588,496	116,809	40,202	76,542	80,088
43.00	04300	NURSERY	198,403	99,045	16,212	64,902	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	839,942	279,762	83,684	183,321	0
51.00	05100	RECOVERY ROOM	325,684	152,911	0	100,199	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	339,536	116,924	28,900	76,617	0
53.00	05300	ANESTHESIOLOGY	15,686	7,354	0	4,819	0
53.01	05301	PAIN MANAGEMENT	94,956	34,470	0	22,588	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	874,774	198,504	41,899	130,074	0
54.01	05401	ULTRASOUND	238,666	33,563	0	21,993	0
56.00	05600	RADIO SOTOP	181,906	79,121	0	51,846	0
57.00	05700	CT SCAN	288,743	21,739	0	14,245	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	201,448	46,156	0	30,245	0
59.00	05900	CARDIAC CATHETERIZATION	512,316	90,313	0	59,179	0
60.00	06000	LABORATORY	1,506,221	139,847	36	91,638	0
65.00	06500	RESPIRATORY THERAPY	365,665	59,910	0	39,257	0
66.00	06600	PHYSICAL THERAPY	114,409	10,686	0	7,002	0
67.00	06700	OCCUPATIONAL THERAPY	27,282	4,608	0	3,019	0
68.00	06800	SPEECH PATHOLOGY	35,802	1,379	0	904	0
69.00	06900	ELECTROCARDIOLOGY	348,031	46,742	0	30,629	0
70.00	07000	ELECTROENCEPHALOGRAPHY	115,285	15,064	0	9,871	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,123,707	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,200,865	0	0	0	0
74.00	07400	RENAL DIALYSIS	24,609	2,298	0	1,506	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	GI LAB	425,006	40,434	33,607	26,495	0
76.00	03950	DIABETIC EDUCATION	104,796	17,867	0	11,708	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	189,732	30,047	4,944	19,689	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,055,132	1,917,933	33,730	1,256,772	0
91.00	09100	EMERGENCY	1,434,328	239,685	109,982	157,059	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	621,003	36,286	20,145	23,777	0
98.00	09850	HOME INFUSION	52,086	2,413	0	1,581	0
101.00	10100	HOME HEALTH AGENCY	390,669	26,657	0	17,468	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,485,420	4,708,400	841,682	3,026,135	805,463
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,961	14,558	0	9,539	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,564,276	387,482	6,013	253,907	0
194.00	07950	COMMUNITY SERVICE	157,190	36,941	0	24,206	0
194.01	07951	OFFSITE FREESTANDING PT/OT	400,408	88,187	18,511	57,787	0
194.02	07952	OFFSITE BUILDINGS	31,012	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	29,658,267	5,235,568	866,206	3,371,574	805,463

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140043		Period: From 05/01/2015 To 04/30/2016		Worksheet B Part I Date/Time Prepared: 9/28/2016 10:37 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,503,054					11.00
13.00	01300	NURSING ADMINISTRATION	15,423	1,780,438				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,549	0	949,454			14.00
15.00	01500	PHARMACY	0	0	0	597,061		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,692	0	0	0	4,257,148	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	244,965	470,588	1,124	0	271,913	30.00
31.00	03100	INTENSIVE CARE UNIT	38,362	78,807	628	0	35,567	31.00
43.00	04300	NURSERY	10,402	20,331	0	0	19,133	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	38,393	77,653	3,652	0	257,023	50.00
51.00	05100	RECOVERY ROOM	20,742	41,938	0	0	36,589	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,545	36,260	0	0	34,121	52.00
53.00	05300	ANESTHESIOLOGY	10,622	0	1,062	0	87,866	53.00
53.01	05301	PAIN MANAGEMENT	7,625	12,234	134	0	35,815	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,642	0	174	0	159,402	54.00
54.01	05401	ULTRASOUND	11,862	0	0	0	96,067	54.01
56.00	05600	RADIOISOTOPE	6,401	0	0	0	98,730	56.00
57.00	05700	CT SCAN	16,380	0	0	0	442,898	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,739	0	0	0	138,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,785	40,003	147	0	165,038	59.00
60.00	06000	LABORATORY	85,447	0	311	0	743,218	60.00
65.00	06500	RESPIRATORY THERAPY	23,535	0	631	0	35,171	65.00
66.00	06600	PHYSICAL THERAPY	8,441	0	199	0	6,603	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,177	0	0	0	1,237	67.00
68.00	06800	SPEECH PATHOLOGY	1,632	0	0	0	2,385	68.00
69.00	06900	ELECTROCARDIOLOGY	25,684	51,942	364	0	123,905	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,139	0	0	0	34,544	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	935,694	0	146,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,904	0	0	597,061	355,282	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,400	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	26,343	0	8	0	145,239	75.01
76.00	03950	DIABETIC EDUCATION	5,036	0	318	0	3,517	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	10,308	0	271	0	46,491	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	411,403	560,692	1,849	0	217,816	90.00
91.00	09100	EMERGENCY	97,481	197,155	960	0	375,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	54,852	0	293	0	38,129	95.00
98.00	09850	HOME INFUSION	2,369	4,798	0	0	3,363	98.00
101.00	10100	HOME HEALTH AGENCY	24,366	49,276	0	0	9,778	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,402,246	1,641,677	947,819	597,061	4,169,721	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,491	0	2	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	64,721	119,852	1,599	0	51,906	192.00
194.00	07950	COMMUNITY SERVICE	9,461	18,909	34	0	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	25,135	0	0	0	35,521	194.01
194.02	07952	OFFSITE BUILDINGS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,503,054	1,780,438	949,454	597,061	4,257,148	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet B
Part I
Date/Time Prepared:
9/28/2016 10:37 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,361,652	0	18,361,652	30.00
31.00	03100	INTENSIVE CARE UNIT	3,490,047	0	3,490,047	31.00
43.00	04300	NURSERY	1,249,199	0	1,249,199	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,238,184	0	5,238,184	50.00
51.00	05100	RECOVERY ROOM	2,025,386	0	2,025,386	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,055,530	0	2,055,530	52.00
53.00	05300	ANESTHESIOLOGY	192,302	0	192,302	53.00
53.01	05301	PAIN MANAGEMENT	600,644	0	600,644	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,069,318	0	5,069,318	54.00
54.01	05401	ULTRASOUND	1,389,487	0	1,389,487	54.01
56.00	05600	RADIOISOTOPE	1,170,531	0	1,170,531	56.00
57.00	05700	CT SCAN	1,978,505	0	1,978,505	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,258,573	0	1,258,573	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,006,179	0	3,006,179	59.00
60.00	06000	LABORATORY	8,797,800	0	8,797,800	60.00
65.00	06500	RESPIRATORY THERAPY	2,036,887	0	2,036,887	65.00
66.00	06600	PHYSICAL THERAPY	620,638	0	620,638	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,185	0	150,185	67.00
68.00	06800	SPEECH PATHOLOGY	190,212	0	190,212	68.00
69.00	06900	ELECTROCARDIOLOGY	2,067,067	0	2,067,067	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	658,827	0	658,827	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,128,722	0	17,128,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,557,442	0	22,557,442	73.00
74.00	07400	RENAL DIALYSIS	132,616	0	132,616	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	2,455,338	0	2,455,338	75.01
76.00	03950	DIABETIC EDUCATION	576,773	0	576,773	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,086,385	0	1,086,385	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,094,096	0	20,094,096	90.00
91.00	09100	EMERGENCY	8,545,324	0	8,545,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,363,511	0	3,363,511	95.00
98.00	09850	HOME INFUSION	282,083	0	282,083	98.00
101.00	10100	HOME HEALTH AGENCY	2,134,370	0	2,134,370	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	139,963,813	0	139,963,813	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128,126	0	128,126	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,921,006	0	8,921,006	192.00
194.00	07950	COMMUNITY SERVICE	897,022	0	897,022	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	2,281,995	0	2,281,995	194.01
194.02	07952	OFFSITE BUILDINGS	159,307	0	159,307	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	152,351,269	0	152,351,269	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet B
Part II
Date/Time Prepared:
9/28/2016 10:37 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,396	4,635	17,031	17,031 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	71,912	1,107,695	2,195,787	3,375,394	3,274 5.00
7.00 00700	OPERATION OF PLANT	5,112	210,542	19,472	235,126	320 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	80,939	20,964	101,903	74 8.00
9.00 00900	HOUSEKEEPING	0	8,416	17,892	26,308	288 9.00
10.00 01000	DIETARY	0	25,964	24,456	50,420	64 10.00
11.00 01100	CAFETERIA	0	79,233	74,636	153,869	197 11.00
13.00 01300	NURSING ADMINISTRATION	0	2,456	44,321	46,777	250 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	11,884	39,931	51,815	116 14.00
15.00 01500	PHARMACY	0	24,155	108,122	132,277	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	60,855	71,132	131,987	483 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	537,380	400,491	937,871	2,201 30.00
31.00 03100	INTENSIVE CARE UNIT	504	115,614	108,247	224,365	404 31.00
43.00 04300	NURSERY	0	98,032	49,519	147,551	129 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	66,625	276,901	681,788	1,025,314	429 50.00
51.00 05100	RECOVERY ROOM	0	151,347	66,343	217,690	215 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	115,728	88,274	204,002	229 52.00
53.00 05300	ANESTHESIOLOGY	0	7,278	5,051	12,329	0 53.00
53.01 05301	PAIN MANAGEMENT	0	34,118	8,744	42,862	66 53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	67,000	196,474	727,818	991,292	427 54.00
54.01 05401	ULTRASOUND	0	33,219	81,572	114,791	151 54.01
56.00 05600	RADIOISOTOPE	0	78,312	164,550	242,862	81 56.00
57.00 05700	CT SCAN	0	21,517	130,517	152,034	184 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	45,684	49,583	95,267	115 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	89,389	604,833	694,222	233 59.00
60.00 06000	LABORATORY	0	138,416	300,207	438,623	679 60.00
65.00 06500	RESPIRATORY THERAPY	0	59,297	84,515	143,812	248 65.00
66.00 06600	PHYSICAL THERAPY	0	10,577	4,352	14,929	89 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,560	0	4,560	21 67.00
68.00 06800	SPEECH PATHOLOGY	0	1,365	0	1,365	29 68.00
69.00 06900	ELECTROCARDIOLOGY	0	46,264	116,365	162,629	225 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	589	14,910	23,162	38,661	71 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	319 73.00
74.00 07400	RENAL DIALYSIS	0	2,275	0	2,275	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01 07501	GI LAB	0	40,020	242,263	282,283	263 75.01
76.00 03950	DIABETIC EDUCATION	0	17,684	3,366	21,050	53 76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	29,739	16,901	46,640	81 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	1,898,325	492,726	2,391,051	1,906 90.00
91.00 09100	EMERGENCY	0	237,233	744,985	982,218	946 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	35,915	75,295	111,210	450 95.00
98.00 09850	HOME INFUSION	0	2,388	0	2,388	19 98.00
101.00 10100	HOME HEALTH AGENCY	0	26,385	35,379	61,764	287 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	211,742	5,990,881	7,928,194	14,130,817	15,616 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,409	2,557	16,966	6 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	52,453	383,520	24,763	460,736	1,010 192.00
194.00 07950	COMMUNITY SERVICE	0	36,563	122	36,685	102 194.00
194.01 07951	OFFSITE FREESTANDING PT/OT	0	87,285	0	87,285	297 194.01
194.02 07952	OFFSITE BUILDINGS	0	0	0	0	0 194.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	264,195	6,512,658	7,955,636	14,732,489	17,031 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part II Date/Time Prepared: 9/28/2016 10:37 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	3,378,668				5.00	
7.00	00700	OPERATION OF PLANT	116,110	351,556			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	17,396	5,491	124,864		8.00	
9.00	00900	HOUSEKEEPING	73,049	571	9,971	110,187	9.00	
10.00	01000	DIETARY	16,816	1,761	548	562	70,171	10.00
11.00	01100	CAFETERIA	30,137	5,375	1,674	1,714	0	11.00
13.00	01300	NURSING ADMINISTRATION	39,052	167	0	53	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,271	806	0	257	0	14.00
15.00	01500	PHARMACY	12,345	1,639	0	523	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	90,786	4,128	0	1,317	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	341,644	36,457	49,553	11,627	63,194	30.00
31.00	03100	INTENSIVE CARE UNIT	67,043	7,843	5,795	2,501	6,977	31.00
43.00	04300	NURSERY	22,602	6,651	2,337	2,121	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	95,688	18,785	12,063	5,991	0	50.00
51.00	05100	RECOVERY ROOM	37,103	10,268	0	3,275	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,681	7,851	4,166	2,504	0	52.00
53.00	05300	ANESTHESIOLOGY	1,787	494	0	157	0	53.00
53.01	05301	PAIN MANAGEMENT	10,818	2,315	0	738	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,656	13,329	6,040	4,251	0	54.00
54.01	05401	ULTRASOUND	27,189	2,254	0	719	0	54.01
56.00	05600	RADIO SOTOP	20,723	5,313	0	1,694	0	56.00
57.00	05700	CT SCAN	32,894	1,460	0	466	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,949	3,099	0	988	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	58,364	6,064	0	1,934	0	59.00
60.00	06000	LABORATORY	171,592	9,390	5	2,995	0	60.00
65.00	06500	RESPIRATORY THERAPY	41,657	4,023	0	1,283	0	65.00
66.00	06600	PHYSICAL THERAPY	13,034	718	0	229	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,108	309	0	99	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,079	93	0	30	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,648	3,139	0	1,001	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,134	1,011	0	323	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	355,859	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	478,513	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,803	154	0	49	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	48,417	2,715	4,844	866	0	75.01
76.00	03950	DIABETIC EDUCATION	11,939	1,200	0	383	0	76.00
76.98	07698	HYPERBARI C OXYGEN THERAPY	21,615	2,018	713	643	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	348,046	128,783	4,862	41,071	0	90.00
91.00	09100	EMERGENCY	163,401	16,094	15,854	5,133	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	70,746	2,437	2,904	777	0	95.00
98.00	09850	HOME INFUSION	5,934	162	0	52	0	98.00
101.00	10100	HOME HEALTH AGENCY	44,506	1,790	0	571	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,131,134	316,157	121,329	98,897	70,171	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,274	978	0	312	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	178,205	26,019	867	8,298	0	192.00
194.00	07950	COMMUNITY SERVICE	17,907	2,480	0	791	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	45,615	5,922	2,668	1,889	0	194.01
194.02	07952	OFFSITE BUILDINGS	3,533	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,378,668	351,556	124,864	110,187	70,171	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043		Period: From 05/01/2015 To 04/30/2016		Worksheet B Part II Date/Time Prepared: 9/28/2016 10:37 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						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	192,966					11.00
13.00	01300	1,980	88,279				13.00
14.00	01400	1,996	0	75,261			14.00
15.00	01500	0	0	0	146,784		15.00
16.00	01600	7,920	0	0	0	236,621	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	31,449	23,333	89	0	15,104	30.00
31.00	03100	4,925	3,907	50	0	1,976	31.00
43.00	04300	1,335	1,008	0	0	1,063	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,929	3,850	290	0	14,277	50.00
51.00	05100	2,663	2,079	0	0	2,032	51.00
52.00	05200	2,381	1,798	0	0	1,895	52.00
53.00	05300	1,364	0	84	0	4,881	53.00
53.01	05301	979	607	11	0	1,989	53.01
54.00	05400	5,860	0	14	0	8,854	54.00
54.01	05401	1,523	0	0	0	5,336	54.01
56.00	05600	822	0	0	0	5,484	56.00
57.00	05700	2,103	0	0	0	24,602	57.00
58.00	05800	1,122	0	0	0	7,700	58.00
59.00	05900	2,540	1,983	12	0	9,167	59.00
60.00	06000	10,970	0	25	0	41,432	60.00
65.00	06500	3,021	0	50	0	1,954	65.00
66.00	06600	1,084	0	16	0	367	66.00
67.00	06700	151	0	0	0	69	67.00
68.00	06800	209	0	0	0	132	68.00
69.00	06900	3,297	2,575	29	0	6,883	69.00
70.00	07000	917	0	0	0	1,919	70.00
71.00	07100	0	0	74,168	0	8,158	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	3,326	0	0	146,784	19,735	73.00
74.00	07400	0	0	0	0	133	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	3,382	0	1	0	8,068	75.01
76.00	03950	647	0	25	0	195	76.00
76.98	07698	1,323	0	21	0	2,582	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	52,817	27,802	147	0	12,099	90.00
91.00	09100	12,515	9,775	76	0	20,831	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	7,042	0	23	0	2,118	95.00
98.00	09850	304	238	0	0	187	98.00
101.00	10100	3,128	2,443	0	0	543	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		180,024	81,398	75,131	146,784	231,765	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	191	0	0	0	0	190.00
192.00	19200	8,309	5,943	127	0	2,883	192.00
194.00	07950	1,215	938	3	0	0	194.00
194.01	07951	3,227	0	0	0	1,973	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		192,966	88,279	75,261	146,784	236,621	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part II Date/Time Prepared: 9/28/2016 10:37 am
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,512,522	0	1,512,522	30.00
31.00	03100	INTENSIVE CARE UNIT	325,786	0	325,786	31.00
43.00	04300	NURSERY	184,797	0	184,797	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,181,616	0	1,181,616	50.00
51.00	05100	RECOVERY ROOM	275,325	0	275,325	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	263,507	0	263,507	52.00
53.00	05300	ANESTHESIOLOGY	21,096	0	21,096	53.00
53.01	05301	PAIN MANAGEMENT	60,385	0	60,385	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,129,723	0	1,129,723	54.00
54.01	05401	ULTRASOUND	151,963	0	151,963	54.01
56.00	05600	RADIOISOTOPE	276,979	0	276,979	56.00
57.00	05700	CT SCAN	213,743	0	213,743	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	131,240	0	131,240	58.00
59.00	05900	CARDIAC CATHETERIZATION	774,519	0	774,519	59.00
60.00	06000	LABORATORY	675,711	0	675,711	60.00
65.00	06500	RESPIRATORY THERAPY	196,048	0	196,048	65.00
66.00	06600	PHYSICAL THERAPY	30,466	0	30,466	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,317	0	8,317	67.00
68.00	06800	SPEECH PATHOLOGY	5,937	0	5,937	68.00
69.00	06900	ELECTROCARDIOLOGY	219,426	0	219,426	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56,036	0	56,036	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	438,185	0	438,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	648,677	0	648,677	73.00
74.00	07400	RENAL DIALYSIS	5,414	0	5,414	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	350,839	0	350,839	75.01
76.00	03950	DIABETIC EDUCATION	35,492	0	35,492	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	75,636	0	75,636	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,008,584	0	3,008,584	90.00
91.00	09100	EMERGENCY	1,226,843	0	1,226,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	197,707	0	197,707	95.00
98.00	09850	HOME INFUSION	9,284	0	9,284	98.00
101.00	10100	HOME HEALTH AGENCY	115,032	0	115,032	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,806,835	0	13,806,835	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,727	0	20,727	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	692,397	0	692,397	192.00
194.00	07950	COMMUNITY SERVICE	60,121	0	60,121	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	148,876	0	148,876	194.01
194.02	07952	OFFSITE BUILDINGS	3,533	0	3,533	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,732,489	0	14,732,489	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet B-1

Date/Time Prepared:
9/28/2016 10:37 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				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	572,660				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		7,879,653			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,090	4,591	57,915,370		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	97,400	2,174,816	11,124,403	-29,658,267	5.00
7.00 00700	OPERATION OF PLANT	18,513	19,286	1,089,228	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	7,117	20,764	253,097	0	8.00
9.00 00900	HOUSEKEEPING	740	17,721	981,280	0	9.00
10.00 01000	DIETARY	2,283	24,222	219,352	0	10.00
11.00 01100	CAFETERIA	6,967	73,923	669,359	0	11.00
13.00 01300	NURSING ADMINISTRATION	216	43,898	852,017	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,045	39,550	393,160	0	14.00
15.00 01500	PHARMACY	2,124	107,089	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,351	70,453	1,643,396	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	47,252	396,666	7,485,950	0	30.00
31.00 03100	INTENSIVE CARE UNIT	10,166	107,213	1,373,336	0	31.00
43.00 04300	NURSERY	8,620	49,046	437,501	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	24,348	675,276	1,458,893	0	50.00
51.00 05100	RECOVERY ROOM	13,308	65,709	730,029	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,176	87,431	780,241	0	52.00
53.00 05300	ANESTHESIOLOGY	640	5,003	0	0	53.00
53.01 05301	PAIN MANAGEMENT	3,000	8,660	223,391	0	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,276	720,867	1,453,106	0	54.00
54.01 05401	ULTRASOUND	2,921	80,793	512,615	0	54.01
56.00 05600	RADIOISOTOPE	6,886	162,978	277,006	0	56.00
57.00 05700	CT SCAN	1,892	129,270	624,680	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,017	49,109	392,032	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	7,860	599,056	791,027	0	59.00
60.00 06000	LABORATORY	12,171	297,340	2,309,687	0	60.00
65.00 06500	RESPIRATORY THERAPY	5,214	83,708	842,415	0	65.00
66.00 06600	PHYSICAL THERAPY	930	4,310	302,527	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	401	0	71,301	0	67.00
68.00 06800	SPEECH PATHOLOGY	120	0	97,088	0	68.00
69.00 06900	ELECTROCARDIOLOGY	4,068	115,254	765,981	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,311	22,941	240,325	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	1,085,480	0	73.00
74.00 07400	RENAL DIALYSIS	200	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	239,949	894,888	0	75.01
76.00 03950	DIABETIC EDUCATION	1,555	3,334	180,856	0	76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	2,615	16,740	275,812	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	166,920	488,020	6,481,863	0	90.00
91.00 09100	EMERGENCY	20,860	737,870	3,218,824	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,158	74,576	1,528,990	0	95.00
98.00 09850	HOME INFUSION	210	0	65,026	0	98.00
101.00 10100	HOME HEALTH AGENCY	2,320	35,041	977,691	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	526,780	7,852,473	53,103,853	-29,658,267	113,704,155
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,267	2,533	20,843	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	33,723	24,526	3,434,687	0	192.00
194.00 07950	COMMUNITY SERVICE	3,215	121	345,740	0	194.00
194.01 07951	OFFSITE FREESTANDING PT/OT	7,675	0	1,010,247	0	194.01
194.02 07952	OFFSITE BUILDINGS	0	0	0	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	6,512,658	7,955,636	28,366,502		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.372643	1.009643	0.489792		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			17,031		204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet B-1
Date/Time Prepared:
9/28/2016 10:37 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				
205.00 Unit cost multiplier (Wkst. B, Part II)			4.00 0.000294	5A	5.00 0.027538	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet B-1

Date/Time Prepared:
9/28/2016 10:37 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	
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	455,657					7.00
8.00	00800	7,117	927,482				8.00
9.00	00900	740	74,063	447,800			9.00
10.00	01000	2,283	4,073	2,283	56,009		10.00
11.00	01100	6,967	12,432	6,967	0	95,798	11.00
13.00	01300	216	0	216	0	983	13.00
14.00	01400	1,045	0	1,045	0	991	14.00
15.00	01500	2,124	0	2,124	0	0	15.00
16.00	01600	5,351	0	5,351	0	3,932	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	47,252	368,075	47,252	50,440	15,613	30.00
31.00	03100	10,166	43,046	10,166	5,569	2,445	31.00
43.00	04300	8,620	17,359	8,620	0	663	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	24,348	89,604	24,348	0	2,447	50.00
51.00	05100	13,308	0	13,308	0	1,322	51.00
52.00	05200	10,176	30,944	10,176	0	1,182	52.00
53.00	05300	640	0	640	0	677	53.00
53.01	05301	3,000	0	3,000	0	486	53.01
54.00	05400	17,276	44,863	17,276	0	2,909	54.00
54.01	05401	2,921	0	2,921	0	756	54.01
56.00	05600	6,886	0	6,886	0	408	56.00
57.00	05700	1,892	0	1,892	0	1,044	57.00
58.00	05800	4,017	0	4,017	0	557	58.00
59.00	05900	7,860	0	7,860	0	1,261	59.00
60.00	06000	12,171	39	12,171	0	5,446	60.00
65.00	06500	5,214	0	5,214	0	1,500	65.00
66.00	06600	930	0	930	0	538	66.00
67.00	06700	401	0	401	0	75	67.00
68.00	06800	120	0	120	0	104	68.00
69.00	06900	4,068	0	4,068	0	1,637	69.00
70.00	07000	1,311	0	1,311	0	455	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	1,651	73.00
74.00	07400	200	0	200	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	3,519	35,984	3,519	0	1,679	75.01
76.00	03950	1,555	0	1,555	0	321	76.00
76.98	07698	2,615	5,294	2,615	0	657	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	166,920	36,116	166,920	0	26,221	90.00
91.00	09100	20,860	117,762	20,860	0	6,213	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	3,158	21,570	3,158	0	3,496	95.00
98.00	09850	210	0	210	0	151	98.00
101.00	10100	2,320	0	2,320	0	1,553	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		409,777	901,224	401,920	56,009	89,373	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,267	0	1,267	0	95	190.00
192.00	19200	33,723	6,438	33,723	0	4,125	192.00
194.00	07950	3,215	0	3,215	0	603	194.00
194.01	07951	7,675	19,820	7,675	0	1,602	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		5,235,568	866,206	3,371,574	805,463	1,503,054	202.00
203.00		11.490152	0.933933	7.529196	14.380957	15.689827	203.00
204.00		351,556	124,864	110,187	70,171	192,966	204.00
205.00		0.771536	0.134627	0.246063	1.252852	2.014301	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet B-1

Date/Time Prepared:
9/28/2016 10:37 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	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	1,211,984				13.00
14.00	01400	0	13,112,492			14.00
15.00	01500	0	0	16,706,598		15.00
16.00	01600	0	0	0	627,208,992	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	320,340	15,523	0	40,063,799	30.00
31.00	03100	53,646	8,676	0	5,240,515	31.00
43.00	04300	13,840	0	0	2,819,034	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	52,860	50,439	0	37,869,831	50.00
51.00	05100	28,548	0	0	5,390,974	51.00
52.00	05200	24,683	0	0	5,027,469	52.00
53.00	05300	0	14,669	0	12,946,289	53.00
53.01	05301	8,328	1,854	0	5,277,060	53.01
54.00	05400	0	2,400	0	23,486,354	54.00
54.01	05401	0	0	0	14,154,600	54.01
56.00	05600	0	0	0	14,546,870	56.00
57.00	05700	0	0	0	65,256,753	57.00
58.00	05800	0	0	0	20,423,461	58.00
59.00	05900	27,231	2,036	0	24,316,806	59.00
60.00	06000	0	4,297	0	109,464,567	60.00
65.00	06500	0	8,719	0	5,182,133	65.00
66.00	06600	0	2,742	0	972,893	66.00
67.00	06700	0	0	0	182,275	67.00
68.00	06800	0	0	0	351,353	68.00
69.00	06900	35,358	5,024	0	18,256,263	69.00
70.00	07000	0	0	0	5,089,728	70.00
71.00	07100	0	12,922,459	0	21,638,775	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	16,706,598	52,347,406	73.00
74.00	07400	0	0	0	353,626	74.00
75.00	07500	0	0	0	0	75.00
75.01	07501	0	114	0	21,399,649	75.01
76.00	03950	0	4,392	0	518,215	76.00
76.98	07698	0	3,740	0	6,849,942	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	381,675	25,529	0	32,093,163	90.00
91.00	09100	134,208	13,264	0	55,253,438	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	4,046	0	5,617,924	95.00
98.00	09850	3,266	0	0	495,534	98.00
101.00	10100	33,543	0	0	1,440,660	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		1,117,526	13,089,923	16,706,598	614,327,359	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	25	0	0	190.00
192.00	19200	81,586	22,080	0	7,647,894	192.00
194.00	07950	12,872	464	0	0	194.00
194.01	07951	0	0	0	5,233,739	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		1,780,438	949,454	597,061	4,257,148	202.00
203.00		1.469028	0.072408	0.035738	0.006787	203.00
204.00		88,279	75,261	146,784	236,621	204.00
205.00		0.072838	0.005740	0.008786	0.000377	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet C
Part I
Date/Time Prepared:
9/28/2016 10:37 am

		Title XVIII		Hospital		PPS
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	Total Costs
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	18,361,652		18,361,652	0	18,361,652
31.00	03100 INTENSIVE CARE UNIT	3,490,047		3,490,047	0	3,490,047
43.00	04300 NURSERY	1,249,199		1,249,199	0	1,249,199
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,238,184		5,238,184	0	5,238,184
51.00	05100 RECOVERY ROOM	2,025,386		2,025,386	0	2,025,386
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,055,530		2,055,530	0	2,055,530
53.00	05300 ANESTHESIOLOGY	192,302		192,302	0	192,302
53.01	05301 PAIN MANAGEMENT	600,644		600,644	0	600,644
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,069,318		5,069,318	0	5,069,318
54.01	05401 ULTRASOUND	1,389,487		1,389,487	0	1,389,487
56.00	05600 RADIOISOTOPE	1,170,531		1,170,531	0	1,170,531
57.00	05700 CT SCAN	1,978,505		1,978,505	0	1,978,505
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,258,573		1,258,573	0	1,258,573
59.00	05900 CARDIAC CATHETERIZATION	3,006,179		3,006,179	0	3,006,179
60.00	06000 LABORATORY	8,797,800		8,797,800	0	8,797,800
65.00	06500 RESPIRATORY THERAPY	2,036,887	0	2,036,887	0	2,036,887
66.00	06600 PHYSICAL THERAPY	620,638	0	620,638	0	620,638
67.00	06700 OCCUPATIONAL THERAPY	150,185	0	150,185	0	150,185
68.00	06800 SPEECH PATHOLOGY	190,212	0	190,212	0	190,212
69.00	06900 ELECTROCARDIOLOGY	2,067,067		2,067,067	0	2,067,067
70.00	07000 ELECTROENCEPHALOGRAPHY	658,827		658,827	0	658,827
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,128,722		17,128,722	0	17,128,722
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	22,557,442		22,557,442	0	22,557,442
74.00	07400 RENAL DIALYSIS	132,616		132,616	0	132,616
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0
75.01	07501 GI LAB	2,455,338		2,455,338	0	2,455,338
76.00	03950 DIABETIC EDUCATION	576,773		576,773	0	576,773
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,086,385		1,086,385	0	1,086,385
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	20,094,096		20,094,096	0	20,094,096
91.00	09100 EMERGENCY	8,545,324		8,545,324	0	8,545,324
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,111,089		4,111,089	0	4,111,089
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	3,363,511		3,363,511	0	3,363,511
98.00	09850 HOME INFUSION	282,083		282,083	0	282,083
101.00	10100 HOME HEALTH AGENCY	2,134,370		2,134,370	0	2,134,370
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	144,074,902	0	144,074,902	0	144,074,902
201.00	Less Observation Beds	4,111,089		4,111,089		4,111,089
202.00	Total (see instructions)	139,963,813	0	139,963,813	0	139,963,813

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140043		Period: From 05/01/2015 To 04/30/2016		Worksheet C Part I Date/Time Prepared: 9/28/2016 10:37 am	
			Title XVIIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,832,302		33,832,302			30.00
31.00	03100	INTENSIVE CARE UNIT	5,240,515		5,240,515			31.00
43.00	04300	NURSERY	2,819,034		2,819,034			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,607,172	24,262,659	37,869,831	0.138321	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,321,683	4,069,291	5,390,974	0.375699	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,303,770	1,723,699	5,027,469	0.408860	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,728,567	7,217,722	12,946,289	0.014854	0.000000	53.00
53.01	05301	PAIN MANAGEMENT	4,249	5,272,811	5,277,060	0.113822	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,691,383	20,794,971	23,486,354	0.215841	0.000000	54.00
54.01	05401	ULTRASOUND	1,279,655	12,874,945	14,154,600	0.098165	0.000000	54.01
56.00	05600	RADIOISOTOPE	1,447,647	13,099,223	14,546,870	0.080466	0.000000	56.00
57.00	05700	CT SCAN	13,549,426	51,707,327	65,256,753	0.030319	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,660,637	18,762,824	20,423,461	0.061624	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,931,285	14,385,521	24,316,806	0.123626	0.000000	59.00
60.00	06000	LABORATORY	24,447,826	85,016,741	109,464,567	0.080371	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,420,736	1,761,397	5,182,133	0.393060	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	870,063	102,830	972,893	0.637930	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	106,391	75,884	182,275	0.823947	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	89,227	262,126	351,353	0.541370	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,248,905	14,007,358	18,256,263	0.113225	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70,042	5,019,686	5,089,728	0.129442	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,179,234	10,459,541	21,638,775	0.791575	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	17,733,763	34,613,643	52,347,406	0.430918	0.000000	73.00
74.00	07400	RENAL DIALYSIS	316,709	36,917	353,626	0.375018	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	1,783,295	19,616,354	21,399,649	0.114737	0.000000	75.01
76.00	03950	DIABETIC EDUCATION	42	518,173	518,215	1.112999	0.000000	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	80,660	6,769,282	6,849,942	0.158598	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	62,719	32,030,444	32,093,163	0.626118	0.000000	90.00
91.00	09100	EMERGENCY	11,200,434	44,053,004	55,253,438	0.154657	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	748,020	5,483,477	6,231,497	0.659727	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,435	5,613,489	5,617,924	0.598711	0.000000	95.00
98.00	09850	HOME INFUSION	0	495,534	495,534	0.569251	0.000000	98.00
101.00	10100	HOME HEALTH AGENCY	0	1,440,660	1,440,660			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	172,779,826	441,547,533	614,327,359			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	172,779,826	441,547,533	614,327,359			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Prepared: 9/28/2016 10:37 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.138321		50.00
51.00	05100 RECOVERY ROOM	0.375699		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.408860		52.00
53.00	05300 ANESTHESIOLOGY	0.014854		53.00
53.01	05301 PAIN MANAGEMENT	0.113822		53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.215841		54.00
54.01	05401 ULTRASOUND	0.098165		54.01
56.00	05600 RADIOISOTOPE	0.080466		56.00
57.00	05700 CT SCAN	0.030319		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.061624		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.123626		59.00
60.00	06000 LABORATORY	0.080371		60.00
65.00	06500 RESPIRATORY THERAPY	0.393060		65.00
66.00	06600 PHYSICAL THERAPY	0.637930		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.823947		67.00
68.00	06800 SPEECH PATHOLOGY	0.541370		68.00
69.00	06900 ELECTROCARDIOLOGY	0.113225		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.129442		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.791575		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.430918		73.00
74.00	07400 RENAL DIALYSIS	0.375018		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501 GI LAB	0.114737		75.01
76.00	03950 DIABETIC EDUCATION	1.112999		76.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.158598		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.626118		90.00
91.00	09100 EMERGENCY	0.154657		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.659727		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.598711		95.00
98.00	09850 HOME INFUSION	0.569251		98.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140043		Period: From 05/01/2015 To 04/30/2016		Worksheet D Part I Date/Time Prepared: 9/28/2016 10:37 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	1,512,522	0	1,512,522	16,271	92.96	30.00	
31.00	INTENSIVE CARE UNIT	325,786		325,786	1,520	214.33	31.00	
43.00	NURSERY	184,797		184,797	946	195.35	43.00	
200.00	Total (Lines 30-199)	2,023,105		2,023,105	18,737		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	7,225	671,636					30.00
31.00	INTENSIVE CARE UNIT	991	212,401					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (Lines 30-199)	8,216	884,037					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part II Date/Time Prepared: 9/28/2016 10:37 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,181,616	37,869,831	0.031202	6,236,412	194,589	50.00
51.00	05100	RECOVERY ROOM	275,325	5,390,974	0.051071	636,044	32,483	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	263,507	5,027,469	0.052413	12,994	681	52.00
53.00	05300	ANESTHESIOLOGY	21,096	12,946,289	0.001630	2,755,705	4,492	53.00
53.01	05301	PAIN MANAGEMENT	60,385	5,277,060	0.011443	3,270	37	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,129,723	23,486,354	0.048101	1,706,735	82,096	54.00
54.01	05401	ULTRASOUND	151,963	14,154,600	0.010736	716,556	7,693	54.01
56.00	05600	RADIOISOTOPE	276,979	14,546,870	0.019040	994,712	18,939	56.00
57.00	05700	CT SCAN	213,743	65,256,753	0.003275	7,673,279	25,130	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	131,240	20,423,461	0.006426	951,266	6,113	58.00
59.00	05900	CARDIAC CATHETERIZATION	774,519	24,316,806	0.031851	4,774,920	152,086	59.00
60.00	06000	LABORATORY	675,711	109,464,567	0.006173	14,700,430	90,746	60.00
65.00	06500	RESPIRATORY THERAPY	196,048	5,182,133	0.037832	2,192,431	82,944	65.00
66.00	06600	PHYSICAL THERAPY	30,466	972,893	0.031315	586,011	18,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,317	182,275	0.045629	62,586	2,856	67.00
68.00	06800	SPEECH PATHOLOGY	5,937	351,353	0.016898	73,491	1,242	68.00
69.00	06900	ELECTROCARDIOLOGY	219,426	18,256,263	0.012019	2,720,817	32,701	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56,036	5,089,728	0.011010	39,877	439	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	438,185	21,638,775	0.020250	5,900,226	119,480	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	648,677	52,347,406	0.012392	10,636,273	131,805	73.00
74.00	07400	RENAL DIALYSIS	5,414	353,626	0.015310	236,936	3,627	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	GI LAB	350,839	21,399,649	0.016395	1,148,158	18,824	75.01
76.00	03950	DIABETIC EDUCATION	35,492	518,215	0.068489	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	75,636	6,849,942	0.011042	68,021	751	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,008,584	32,093,163	0.093745	55,579	5,210	90.00
91.00	09100	EMERGENCY	1,226,843	55,253,438	0.022204	6,472,282	143,711	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	338,647	6,231,497	0.054344	426,836	23,196	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	HOME INFUSION	9,284	495,534	0.018735	0	0	98.00
200.00		Total (Lines 50-199)	11,809,638	565,376,924		71,781,847	1,200,222	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140043		Period: From 05/01/2015 To 04/30/2016		Worksheet D Part III Date/Time Prepared: 9/28/2016 10:37 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	16,271	0.00	7,225	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,520	0.00	991	0		31.00
43.00	04300	NURSERY	946	0.00	0	0		43.00
200.00		Total (lines 30-199)	18,737		8,216	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet D
Part IV
Date/Time Prepared:
9/28/2016 10:37 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
53.01	05301	PAIN MANAGEMENT	0	0	0	0	53.01	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00	
54.01	05401	ULTRASOUND	0	0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00	
57.00	05700	CT SCAN	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	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	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00	
75.01	07501	GI LAB	0	0	0	0	75.01	
76.00	03950	DIABETIC EDUCATION	0	0	0	0	76.00	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
98.00	09850	HOME INFUSION	0	0	0	0	98.00	
200.00		Total (lines 50-199)	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part IV Date/Time Prepared: 9/28/2016 10:37 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	37,869,831	0.000000	0.000000	6,236,412	50.00
51.00	05100	RECOVERY ROOM	0	5,390,974	0.000000	0.000000	636,044	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,027,469	0.000000	0.000000	12,994	52.00
53.00	05300	ANESTHESIOLOGY	0	12,946,289	0.000000	0.000000	2,755,705	53.00
53.01	05301	PAIN MANAGEMENT	0	5,277,060	0.000000	0.000000	3,270	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,486,354	0.000000	0.000000	1,706,735	54.00
54.01	05401	ULTRASOUND	0	14,154,600	0.000000	0.000000	716,556	54.01
56.00	05600	RADIOISOTOPE	0	14,546,870	0.000000	0.000000	994,712	56.00
57.00	05700	CT SCAN	0	65,256,753	0.000000	0.000000	7,673,279	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	20,423,461	0.000000	0.000000	951,266	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	24,316,806	0.000000	0.000000	4,774,920	59.00
60.00	06000	LABORATORY	0	109,464,567	0.000000	0.000000	14,700,430	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,182,133	0.000000	0.000000	2,192,431	65.00
66.00	06600	PHYSICAL THERAPY	0	972,893	0.000000	0.000000	586,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	182,275	0.000000	0.000000	62,586	67.00
68.00	06800	SPEECH PATHOLOGY	0	351,353	0.000000	0.000000	73,491	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,256,263	0.000000	0.000000	2,720,817	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,089,728	0.000000	0.000000	39,877	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,638,775	0.000000	0.000000	5,900,226	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	52,347,406	0.000000	0.000000	10,636,273	73.00
74.00	07400	RENAL DIALYSIS	0	353,626	0.000000	0.000000	236,936	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	GI LAB	0	21,399,649	0.000000	0.000000	1,148,158	75.01
76.00	03950	DIABETIC EDUCATION	0	518,215	0.000000	0.000000	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	6,849,942	0.000000	0.000000	68,021	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	32,093,163	0.000000	0.000000	55,579	90.00
91.00	09100	EMERGENCY	0	55,253,438	0.000000	0.000000	6,472,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,231,497	0.000000	0.000000	426,836	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	09850	HOME INFUSION	0	495,534	0.000000	0.000000	0	98.00
200.00		Total (Lines 50-199)	0	565,376,924			71,781,847	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet D
Part IV
Date/Time Prepared:
9/28/2016 10:37 am

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
ANCILLARY SERVICE COST CENTERS			11.00	12.00	13.00		
50.00	05000	OPERATING ROOM	0	7,722,041	0		50.00
51.00	05100	RECOVERY ROOM	0	1,424,630	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,112,396	0		53.00
53.01	05301	PAIN MANAGEMENT	0	2,325,184	0		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,666,257	0		54.00
54.01	05401	ULTRASOUND	0	3,545,227	0		54.01
56.00	05600	RADIOISOTOPE	0	5,820,403	0		56.00
57.00	05700	CT SCAN	0	18,280,586	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,943,196	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,226,273	0		59.00
60.00	06000	LABORATORY	0	18,095,925	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	644,622	0		65.00
66.00	06600	PHYSICAL THERAPY	0	18,228	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	954	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	836	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,388,347	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,562,583	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,010,394	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,983,075	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501	GI LAB	0	6,569,367	0		75.01
76.00	03950	DIABETIC EDUCATION	0	13,519	0		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	3,393,672	0		76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	15,775,252	0		90.00
91.00	09100	EMERGENCY	0	11,905,905	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,243,014	0		92.00
OTHER REIMBURSABLE COST CENTERS							
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	142,671,886	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part V Date/Time Prepared: 9/28/2016 10:37 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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.138321	7,722,041	0	0	1,068,120	50.00
51.00 05100 RECOVERY ROOM	0.375699	1,424,630	0	0	535,232	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.408860	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.014854	2,112,396	0	0	31,378	53.00
53.01 05301 PAIN MANAGEMENT	0.113822	2,325,184	0	0	264,657	53.01
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.215841	5,666,257	0	0	1,223,011	54.00
54.01 05401 ULTRASOUND	0.098165	3,545,227	0	0	348,017	54.01
56.00 05600 RADIO SOTOP	0.080466	5,820,403	0	0	468,345	56.00
57.00 05700 CT SCAN	0.030319	18,280,586	0	0	554,249	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.061624	4,943,196	0	0	304,620	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.123626	6,226,273	0	0	769,729	59.00
60.00 06000 LABORATORY	0.080371	18,095,925	15,801	0	1,454,388	60.00
65.00 06500 RESPIRATORY THERAPY	0.393060	644,622	0	0	253,375	65.00
66.00 06600 PHYSICAL THERAPY	0.637930	18,228	0	0	11,628	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.823947	954	0	0	786	67.00
68.00 06800 SPEECH PATHOLOGY	0.541370	836	0	0	453	68.00
69.00 06900 ELECTROCARDIOLOGY	0.113225	4,388,347	0	0	496,871	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.129442	1,562,583	0	0	202,264	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.791575	4,010,394	0	0	3,174,528	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	0.430918	15,983,075	384	280,445	6,887,395	73.00
74.00 07400 RENAL DIALYSIS	0.375018	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01 07501 GI LAB	0.114737	6,569,367	0	0	753,749	75.01
76.00 03950 DIABETIC EDUCATION	1.112999	13,519	0	0	15,047	76.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.158598	3,393,672	0	0	538,230	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.626118	15,775,252	228	0	9,877,169	90.00
91.00 09100 EMERGENCY	0.154657	11,905,905	0	0	1,841,332	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.659727	2,243,014	0	0	1,479,777	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0.598711	0	0	0	0	95.00
98.00 09850 HOME INFUSION	0.569251	0	0	0	0	98.00
200.00	Subtotal (see instructions)	142,671,886	16,413	280,445	32,554,350	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	142,671,886	16,413	280,445	32,554,350	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part V Date/Time Prepared: 9/28/2016 10:37 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		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
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	1,270	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	165	120,849		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 03950 DIABETIC EDUCATION	0	0		76.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	143	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
98.00 09850 HOME INFUSION	0	0		98.00
200.00	Subtotal (see instructions)	1,578	120,849	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,578	120,849	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Prepared: 9/28/2016 10:37 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,271	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,271	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)		12,628	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)		7,225	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,361,652	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)		18,361,652	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		18,361,652	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,128.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,153,340	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)		8,153,340	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043		Period: From 05/01/2015 To 04/30/2016		Worksheet D-1	
Date/Time Prepared: 9/28/2016 10:37 am		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,490,047	1,520	2,296.08	991	2,275,415		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)					16,172,790		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,601,545		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)					884,037		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,200,222		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,084,259		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,517,286		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					3,643		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,128.49		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,111,089		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140043		Period: From 05/01/2015 To 04/30/2016		Worksheet D-1 Date/Time Prepared: 9/28/2016 10:37 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,512,522	18,361,652	0.082374	4,111,089	338,647	90.00
91.00	Nursing School cost	0	18,361,652	0.000000	4,111,089	0	91.00
92.00	Allied health cost	0	18,361,652	0.000000	4,111,089	0	92.00
93.00	All other Medical Education	0	18,361,652	0.000000	4,111,089	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet D-3 Date/Time Prepared: 9/28/2016 10:37 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		13,674,491		30.00
31.00	03100 INTENSIVE CARE UNIT		4,511,383		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.138321	6,236,412	862,627	50.00
51.00	05100 RECOVERY ROOM	0.375699	636,044	238,961	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.408860	12,994	5,313	52.00
53.00	05300 ANESTHESIOLOGY	0.014854	2,755,705	40,933	53.00
53.01	05301 PAIN MANAGEMENT	0.113822	3,270	372	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.215841	1,706,735	368,383	54.00
54.01	05401 ULTRASOUND	0.098165	716,556	70,341	54.01
56.00	05600 RADIOISOTOPE	0.080466	994,712	80,040	56.00
57.00	05700 CT SCAN	0.030319	7,673,279	232,646	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.061624	951,266	58,621	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.123626	4,774,920	590,304	59.00
60.00	06000 LABORATORY	0.080371	14,700,430	1,181,488	60.00
65.00	06500 RESPIRATORY THERAPY	0.393060	2,192,431	861,757	65.00
66.00	06600 PHYSICAL THERAPY	0.637930	586,011	373,834	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.823947	62,586	51,568	67.00
68.00	06800 SPEECH PATHOLOGY	0.541370	73,491	39,786	68.00
69.00	06900 ELECTROCARDIOLOGY	0.113225	2,720,817	308,065	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.129442	39,877	5,162	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.791575	5,900,226	4,670,471	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.430918	10,636,273	4,583,361	73.00
74.00	07400 RENAL DIALYSIS	0.375018	236,936	88,855	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	07501 GI LAB	0.114737	1,148,158	131,736	75.01
76.00	03950 DIABETIC EDUCATION	1.112999	0	0	76.00
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.158598	68,021	10,788	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.626118	55,579	34,799	90.00
91.00	09100 EMERGENCY	0.154657	6,472,282	1,000,984	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.659727	426,836	281,595	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 HOME INFUSION	0.569251	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		71,781,847	16,172,790	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)		71,781,847		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/28/2016 10:37 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		6,260,935	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,766,688	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)		557,031	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)		87.05	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.26	30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.49	31.00
32.00	Sum of lines 30 and 31		20.75	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.33	33.00
34.00	Disproportionate share adjustment (see instructions)		253,637	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/28/2016 10:37 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000089627	0.000092992	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	685,434	595,721	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	287,319	346,690	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	634,009		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	17,472,300		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	19,119,054		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		18,707,366	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,320,194	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		1,036	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)		20,028,596	59.00
60.00	Primary payer payments		2,764	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		20,025,832	61.00
62.00	Deductibles billed to program beneficiaries		1,956,920	62.00
63.00	Coinurance billed to program beneficiaries		16,492	63.00
64.00	Allowable bad debts (see instructions)		547,008	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		355,555	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		365,238	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		18,407,975	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		8,500	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-1,446	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		108,360	70.93
70.94	HRR adjustment amount (see instructions)		-17,531	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/28/2016 10:37 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			18,505,858	71.00
71.01	Sequestration adjustment (see instructions)			370,117	71.01
72.00	Interim payments			18,367,063	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)			-231,322	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		516,298	718,768	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0094572443	1.0050316581	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		4,883	3,617	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9972	1.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-1,446	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prepared: 9/28/2016 10:37 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		122,427	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		32,554,350	2.00
3.00	PPS payments		26,671,653	3.00
4.00	Outlier payment (see instructions)		575,097	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)		122,427	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		296,858	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		296,858	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		296,858	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		174,431	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)		122,427	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)		27,246,750	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		5,646,881	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		21,722,296	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)		21,722,296	30.00
31.00	Primary payer payments		2,112	31.00
32.00	Subtotal (line 30 minus line 31)		21,720,184	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,062,839	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		690,845	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		605,317	36.00
37.00	Subtotal (see instructions)		22,411,029	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-14	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		22,411,043	40.00
40.01	Sequestration adjustment (see instructions)		448,221	40.01
41.00	Interim payments		21,858,821	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		104,001	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
9/28/2016 10:37 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		18,394,063		21,744,791	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	12/08/2015	114,030	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	12/08/2015	27,000		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)		-27,000		114,030	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)		18,367,063		21,858,821	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		104,001	6.01
6.02	SETTLEMENT TO PROGRAM		231,322		0	6.02
7.00	Total Medicare program liability (see instructions)		18,135,741		21,962,822	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 05/01/2015
To 04/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
9/28/2016 10:37 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 05/01/2015
To 04/30/2016

Worksheet E-1
Part II
Date/Time Prepared:
9/28/2016 10:37 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	4,648	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	8,216	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	871	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	14,148	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	614,327,359	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	4,410,145	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 140043	Period:	Worksheet E-2
		Component CCN: 14U043	From 05/01/2015 To 04/30/2016	Date/Time Prepared: 9/28/2016 10:37 am
		Title XVIII	Swing Beds - SNF	PPS
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	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 Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part 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		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	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	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		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, chapter 1, §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 05/01/2015
To 04/30/2016

Worksheet G

Date/Time Prepared:
9/28/2016 10:37 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	37,082,493	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	30,245,032	0	0	0	4.00
5.00	Other receivable	1,358,899	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,579,134	0	0	0	7.00
8.00	Prepaid expenses	3,119,964	0	0	0	8.00
9.00	Other current assets	1,553,845	0	0	0	9.00
10.00	Due from other funds	5,822,379	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	82,761,746	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,649,399	0	0	0	12.00
13.00	Land improvements	4,104,653	0	0	0	13.00
14.00	Accumulated depreciation	-2,313,610	0	0	0	14.00
15.00	Buildings	89,348,793	0	0	0	15.00
16.00	Accumulated depreciation	-48,320,831	0	0	0	16.00
17.00	Leasehold improvements	13,733,621	0	0	0	17.00
18.00	Accumulated depreciation	-11,807,998	0	0	0	18.00
19.00	Fixed equipment	509,585	0	0	0	19.00
20.00	Accumulated depreciation	-380,438	0	0	0	20.00
21.00	Automobiles and trucks	504,820	0	0	0	21.00
22.00	Accumulated depreciation	-439,494	0	0	0	22.00
23.00	Major movable equipment	69,353,297	0	0	0	23.00
24.00	Accumulated depreciation	-46,846,461	0	0	0	24.00
25.00	Minor equipment depreciable	16,004,732	0	0	0	25.00
26.00	Accumulated depreciation	-12,198,062	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	553,746	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	74,455,752	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	49,915,090	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	17,811,176	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	67,726,266	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	224,943,764	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,674,518	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,325,831	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,237,749	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	15,029,604	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	34,267,702	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	19,279,830	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	63,416,290	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	82,696,120	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	116,963,822	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	107,979,942				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)	107,979,942	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	224,943,764	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet G-1

Date/Time Prepared:
9/28/2016 10:37 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		85,802,540		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		22,177,402			2.00
3.00	Total (sum of line 1 and line 2)		107,979,942		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)		107,979,942		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)		107,979,942		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 05/01/2015
To 04/30/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/28/2016 10:37 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	33,627,865		33,627,865	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)	33,627,865		33,627,865	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	8,225,894		8,225,894	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)	8,225,894		8,225,894	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	41,853,759		41,853,759	17.00
18.00	Ancillary services	115,570,242	338,264,587	453,834,829	18.00
19.00	Outpatient services	6,305,091	76,584,635	82,889,726	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		1,440,660	1,440,660	22.00
23.00	AMBULANCE SERVICES	4,435	5,613,489	5,617,924	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	15,131,741	157,724,463	172,856,204	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	7,647,894	7,647,894	27.01
27.02	PT/OT/ST NON-PROVIDER BASED	0	5,233,739	5,233,739	27.02
27.03	HOME INFUSION	0	495,534	495,534	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	178,865,268	593,005,001	771,870,269	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		203,398,923		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	603,995			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)		603,995		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		202,794,928		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140043

Period:
From 05/01/2015
To 04/30/2016

Worksheet G-3

Date/Time Prepared:
9/28/2016 10:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	771,870,269	1.00
2.00	Less contractual allowances and discounts on patients' accounts	552,543,917	2.00
3.00	Net patient revenues (line 1 minus line 2)	219,326,352	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	202,794,928	4.00
5.00	Net income from service to patients (line 3 minus line 4)	16,531,424	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	64,428	6.00
7.00	Income from investments	847,757	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	31,669	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	3,421	13.00
14.00	Revenue from meals sold to employees and guests	792,613	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	90,649	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	64,482	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	207,784	22.00
23.00	Governmental appropriations	609,375	23.00
24.00	INCREASE IN EQUITY OF INVESTEES	1,058,925	24.00
24.01	DAYCARE REVENUE	503,419	24.01
24.02	EHR REVENUE	547,263	24.02
24.03	MISCELLANEOUS INCOME	1,483,693	24.03
25.00	Total other income (sum of lines 6-24)	6,305,478	25.00
26.00	Total (line 5 plus line 25)	22,836,902	26.00
27.00	INTEREST EXPENSE	603,995	27.00
27.01	LOSS ON SALE OF ASSET	55,505	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	659,500	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	22,177,402	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140043

Period: From 05/01/2015

Worksheet H

HHA CCN: 147562

To 04/30/2016

Date/Time Prepared: 9/28/2016 10:37 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	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	123,906	0	13,750	0	104,222	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	680,707	0	0	0	680,707	6.00
7.00	Physical Therapy	146,608	0	0	18,153	164,761	7.00
8.00	Occupational Therapy	0	0	0	4,169	4,169	8.00
9.00	Speech Pathology	2,416	0	0	259	2,675	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	24,054	0	0	0	24,054	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
HHA NONREIMBURSABLE SERVICES							
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)	977,691	0	13,750	22,581	1,118,244	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	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	-41,150	200,728	-1,567	199,161		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	680,707	0	680,707		6.00
7.00	Physical Therapy	0	164,761	0	164,761		7.00
8.00	Occupational Therapy	0	4,169	0	4,169		8.00
9.00	Speech Pathology	0	2,675	0	2,675		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	24,054	0	24,054		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
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
24.00	Total (sum of lines 1-23)	-41,150	1,077,094	-1,567	1,075,527		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 05/01/2015 To 04/30/2016	Worksheet H-1 Part I Date/Time Prepared: 9/28/2016 10:37 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
GENERAL SERVICE COST CENTERS								
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	199,161	0	0	0	199,161	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	680,707	0	0	0	680,707	6.00	
7.00	Physical Therapy	164,761	0	0	0	164,761	7.00	
8.00	Occupational Therapy	4,169	0	0	0	4,169	8.00	
9.00	Speech Pathology	2,675	0	0	0	2,675	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	24,054	0	0	0	24,054	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	
HHA NONREIMBURSABLE SERVICES								
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)	1,075,527	0	0	0	1,075,527	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	199,161					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	154,697	835,404				6.00	
7.00	Physical Therapy	37,443	202,204				7.00	
8.00	Occupational Therapy	947	5,116				8.00	
9.00	Speech Pathology	608	3,283				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	5,466	29,520				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	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		1,075,527				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140043

Period:

Worksheet H-1

HHA CCN: 147562

From 05/01/2015
To 04/30/2016

Part II
Date/Time Prepared:
9/28/2016 10:37 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					
GENERAL SERVICE COST CENTERS							
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	-199,161	876,366
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	680,707
7.00	Physical Therapy	0	0	0	0	0	164,761
8.00	Occupational Therapy	0	0	0	0	0	4,169
9.00	Speech Pathology	0	0	0	0	0	2,675
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	24,054
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
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-199,161	876,366
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		199,161
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.227258

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140043

Period: From 05/01/2015 To 04/30/2016

Worksheet H-2 Part I

HHA CCN: 147562

Date/Time Prepared: 9/28/2016 10:37 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	26,385	35,379	60,688	122,452	29,600	1.00
2.00 Skilled Nursing Care	835,404	0	0	333,406	1,168,810	282,532	2.00
3.00 Physical Therapy	202,204	0	0	71,807	274,011	66,236	3.00
4.00 Occupational Therapy	5,116	0	0	0	5,116	1,237	4.00
5.00 Speech Pathology	3,283	0	0	1,183	4,466	1,080	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	29,520	0	0	11,781	41,301	9,984	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)	1,075,527	26,385	35,379	478,865	1,616,156	390,669	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	26,657	0	17,468	0	3,122	49,276	1.00
2.00 Skilled Nursing Care	0	0	0	0	16,726	0	2.00
3.00 Physical Therapy	0	0	0	0	2,918	0	3.00
4.00 Occupational Therapy	0	0	0	0	31	0	4.00
5.00 Speech Pathology	0	0	0	0	47	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	1,522	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)	26,657	0	17,468	0	24,366	49,276	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 05/01/2015 To 04/30/2016	Worksheet H-2 Part I Date/Time Prepared: 9/28/2016 10:37 am
		HHA CCN: 147562	Home Health Agency I	PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	9,778	258,353	0	258,353	1.00
2.00	Skilled Nursing Care	0	0	0	1,468,068	0	1,468,068	2.00
3.00	Physical Therapy	0	0	0	343,165	0	343,165	3.00
4.00	Occupational Therapy	0	0	0	6,384	0	6,384	4.00
5.00	Speech Pathology	0	0	0	5,593	0	5,593	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	52,807	0	52,807	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	9,778	2,134,370	0	2,134,370	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	202,173	1,670,241					2.00
3.00	Physical Therapy	47,259	390,424					3.00
4.00	Occupational Therapy	879	7,263					4.00
5.00	Speech Pathology	770	6,363					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	7,272	60,079					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)	258,353	2,134,370					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.	0.137714						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 05/01/2015 To 04/30/2016

Worksheet H-2 Part II
Date/Time Prepared: 9/28/2016 10:37 am
PPS

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	35,041	123,906	0	122,452	2,320	1.00
2.00 Skilled Nursing Care	0	0	680,707	0	1,168,810	0	2.00
3.00 Physical Therapy	0	0	146,608	0	274,011	0	3.00
4.00 Occupational Therapy	0	0	0	0	5,116	0	4.00
5.00 Speech Pathology	0	0	2,416	0	4,466	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	24,054	0	41,301	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	35,041	977,691		1,616,156	2,320	20.00
21.00 Total cost to be allocated	26,385	35,379	478,865		390,669	26,657	21.00
22.00 Unit cost multiplier	11.372845	1.009646	0.489792		0.241727	11.490086	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	199	33,543	0	1.00
2.00 Skilled Nursing Care	0	0	0	1,066	0	0	2.00
3.00 Physical Therapy	0	0	0	186	0	0	3.00
4.00 Occupational Therapy	0	0	0	2	0	0	4.00
5.00 Speech Pathology	0	0	0	3	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	97	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	1,553	33,543	0	20.00
21.00 Total cost to be allocated	0	17,468	0	24,366	49,276	0	21.00
22.00 Unit cost multiplier	0.000000	7.529310	0.000000	15.689633	1.469040	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140043
HHA CCN: 147562

Period:
From 05/01/2015
To 04/30/2016

Worksheet H-2
Part II
Date/Time Prepared:
9/28/2016 10:37 am
PPS

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	15.00	16.00		
1.00 Administrative and General	0	1,440,660		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	1,440,660		20.00
21.00 Total cost to be allocated	0	9,778		21.00
22.00 Unit cost multiplier	0.000000	0.006787		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet H-3 Part I Date/Time Prepared: 9/28/2016 10:37 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 (col. 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	1,670,241		1,670,241	4,532	368.54	1.00
2.00	Physical Therapy	3.00	390,424	0	390,424	1,959	199.30	2.00
3.00	Occupational Therapy	4.00	7,263	0	7,263	34	213.62	3.00
4.00	Speech Pathology	5.00	6,363	0	6,363	26	244.73	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	60,079		60,079	503	119.44	6.00
7.00	Total (sum of lines 1-6)		2,134,370	0	2,134,370	7,054		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	1,986			8.00
9.00	Physical Therapy		99914	0	1,033			9.00
10.00	Occupational Therapy		99914	0	18			10.00
11.00	Speech Pathology		99914	0	2			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	324			13.00
14.00	Total (sum of lines 8-13)			0	3,363			14.00
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 + col. 4)			
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	13,712	13,712	17,323	0.791549	15.00
16.00	Cost of Drugs	9.00	0	355	355	824	0.430825	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	1,986		0	731,920		1.00
2.00	Physical Therapy	0	1,033		0	205,877		2.00
3.00	Occupational Therapy	0	18		0	3,845		3.00
4.00	Speech Pathology	0	2		0	489		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	324		0	38,699		6.00
7.00	Total (sum of lines 1-6)	0	3,363		0	980,830		7.00
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 05/01/2015 To 04/30/2016		Worksheet H-3 Part I Date/Time Prepared: 9/28/2016 10:37 am		
				Title XVII I		Home Health Agency I		
Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance			Not Subject to Deductibles & Coi nsurance		Subject to Deductibles & Coi nsurance
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	15,287	0	0	12,100	0	
16.00	Cost of Drugs		824	0		355	0	
Cost Center Description		Total Program Cost (sum of col s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	731,920					1.00	
2.00	Physical Therapy	205,877					2.00	
3.00	Occupational Therapy	3,845					3.00	
4.00	Speech Pathology	489					4.00	
5.00	Medical Social Services	0					5.00	
6.00	Home Health Aide	38,699					6.00	
7.00	Total (sum of lines 1-6)	980,830					7.00	
Cost Center Description								
		12.00						
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

Period:

Worksheet H-3

HHA CCN: 147562

From 05/01/2015
To 04/30/2016

Part II
Date/Time Prepared:
9/28/2016 10:37 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		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.637930	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.823947	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.541370	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.791575	17,323	13,712	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.430918	824	355	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140043 HHA CCN: 147562	Period: From 05/01/2015 To 04/30/2016	Worksheet H-4 Part I-11 Date/Time Prepared: 9/28/2016 10:37 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
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	355	0
2.00	Total charges	0	824	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	824	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	469	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
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	355
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	643,232
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	2,028
13.00	Total PPS Reimbursement - LUPA Episodes		0	25,797
14.00	Total PPS Reimbursement - PEP Episodes		0	10,479
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	210
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	682,101
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	682,101
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	682,101
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	682,101
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	682,101
31.01	Sequestration adjustment (see instructions)		0	13,645
32.00	Interim payments (see instructions)		0	668,757
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	-301
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140043	Period: From 05/01/2015 To 04/30/2016	Worksheet H-5
	HHA CCN: 147562	Home Health Agency I	Date/Time Prepared: 9/28/2016 10:37 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		668,757	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		668,757	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		301	6.02
7.00	Total Medicare program liability (see instructions)		0		668,456	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 05/01/2015 To 04/30/2016	Worksheet L Parts I-III Date/Time Prepared: 9/28/2016 10:37 am
		Title XVII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,278,346	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		41,848	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)		39.15	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		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 (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,320,194	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00