

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/23/2016 1:57 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 9/23/2016 Time: 1:57 pm
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 PERRY MEMORIAL HOSPITAL (141337) 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	43,758	-509,210	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	-39,167	0	0	0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RHC-PRINCETON I	0		71,205		0	10.00
200.00 Total	0	4,591	-438,005	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141337		Period: From 05/01/2015 To 04/30/2016		Worksheet S-2 Part I Date/Time Prepared: 9/22/2016 8:10 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 530 PARK AVENUE EAST		PO Box:						1.00			
2.00	City: PRINCETON		State: IL		Zip Code: 61356		County: BUREAU		2.00			
		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	V	XVIII	XIX			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		PERRY MEMORIAL HOSPITAL	141337	99914	1	07/15/2004	N	0	0	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		PERRY MEMORIAL SB/SNF	14Z337	99914		07/15/2004	N	0	N	7.00	
8.00	Swing Beds - NF		PERRY MEMORIAL SB/SNF	14Z337	99914		07/15/2004	N		N	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										12.00	
13.00	Separately Certified ASC										13.00	
14.00	Hospital-Based Hospice										14.00	
15.00	Hospital-Based Health Clinic - RHC		RHC-PRINCETON	148549	99914		11/04/2015	N	0	N	15.00	
16.00	Hospital-Based Health Clinic - FOHC										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)					8			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.					N	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		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.						2		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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.					0	0	0	0	0	0	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	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/22/2016 8:10 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		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.		0				36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N		40.00	
		V	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.					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.					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
61.20	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
						1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	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	0.000000
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.000000

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
					1.00	
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX									
		1.00		2.00									
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00							
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00							
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00							
Rural Providers													
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y				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)	Y				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		Occupational		Speech		Respiratory					
		1.00		2.00		3.00		4.00					
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N		N		N		109.00			
								1.00					
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N				110.00			
								1.00		2.00		3.00	
Miscellaneous Cost Reporting Information													
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0				115.00			
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N								116.00			
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y								117.00			
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1								118.00			
		Premiums		Losses		Insurance							
		1.00		2.00		3.00							
118.01	List amounts of malpractice premiums and paid losses:	227,762		0		0				118.01			
								1.00		2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N								118.02			
119.00	DO NOT USE THIS LINE									119.00			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N						120.00			
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y								121.00			
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N								122.00			
Transplant Center Information													
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N								125.00			
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									126.00			
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									127.00			
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									128.00			
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									129.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									130.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									131.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.									132.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/22/2016 8:10 pm			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
					1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00	
				Part A	Part B	Title V	Title XIX
				1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00
161.00	CMHC		N	N	N	N	161.00
							1.00
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N				165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
168.01	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/22/2016 8:10 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2015	09/30/2015 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. 1, 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: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/22/2016 8:10 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			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)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	06/22/2016	Y	06/22/2016
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: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/22/2016 8:10 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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		Y		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		Y		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.	DAN		LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(563) 888-4404		DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/22/2016 8:10 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141337

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

Worksheet S-3
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					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	22	8,052	49,020.72	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)		22	8,052	49,020.72	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,098	3,417.32	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)		25	9,150	52,438.04	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						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 RHC-PRI NCETON	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				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: 141337

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

Worksheet S-3
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,170	88	1,892			1.00
2.00 HMO and other (see instructions)	169	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	458	0	511			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	24			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,628	88	2,427			7.00
8.00 INTENSIVE CARE UNIT	155	25	271			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		0	0			13.00
14.00 Total (see instructions)	1,783	113	2,698	0.00	288.39	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						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 RHC-PRI NCETON	2,248	1,301	7,485	0.00	11.56	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	299.95	27.00
28.00 Observation Bed Days		0	330			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			22			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			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: 141337

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

Worksheet S-3
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	419	55	740	1.00
2.00 HMO and other (see instructions)			48	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	419	55	740	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						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 RHC-PRINCETON	0.00					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-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141337 Component CCN: 148549		Period: From 05/01/2015 To 04/30/2016		Worksheet S-8 Date/Time Prepared: 9/22/2016 8:10 pm	
				Rural Health Clinic (RHC) I		Cost	
				1.00			
1.00 Clinic Address and Identification				530 PARK AVENUE EAST		1.00	
		City		State		ZIP Code	
		1.00		2.00		3.00	
2.00 City, State, ZIP Code, County		PRINCETON		IL		61356 2.00	
				1.00			
3.00 FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0 3.00	
				Grant Award		Date	
				1.00		2.00	
4.00 Source of Federal Funds							
5.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
6.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
7.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
8.00 Appalachian Regional Commission				0		7.00	
9.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
				1.00		2.00	
10.00 Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0 10.00	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
11.00 Facility hours of operations (1)				07:00		07:00	
11.00 Clinic				07:00		07:00	
				1.00		2.00	
12.00 Have you received an approval for an exception to the productivity standard?				N		0 12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.						0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00 Provider name, CCN number							
		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							
				County			
				4.00			
2.00 City, State, ZIP Code, County				BUREAU		2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00 Facility hours of operations (1)				07:00		07:00	
11.00 Clinic		07:00		07:00		07:00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141337 Component CCN: 148549	Period: From 05/01/2015 To 04/30/2016	Worksheet S-8 Date/Time Prepared: 9/22/2016 8:10 pm Cost
		Rural Health Clinic (RHC) I	

	Friday		Saturday		
	from	to	from	to	
	11.00	11.00	12.00	13.00	
11.00	Facility hours of operations (1) Clinic				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet S-10 Date/Time Prepared: 9/22/2016 8:10 pm
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.423308		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,288,118		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		1,198,485		5.00
6.00	Medicaid charges		6,367,184		6.00
7.00	Medicaid cost (line 1 times line 6)		2,695,280		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)		208,677		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		25,469		9.00
10.00	Stand-alone SCHIP charges		97,313		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		41,193		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		15,724		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)		224,401		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	296,445	88,646	385,091	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	125,488	37,525	163,013	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	125,488	37,525	163,013	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)		1,090,171		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		205,889		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		884,282		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		374,324		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		537,337		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		761,738		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141337

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

Worksheet A
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,196,140	1,196,140	177,086	1,373,226	1.00
1.01	00101		121,032	121,032	0	121,032	1.01
2.00	00200		1,127,387	1,127,387	44,113	1,171,500	2.00
4.00	00400	378,203	6,723,479	7,101,682	-199,561	6,902,121	4.00
5.01	00590	460,426	235,903	696,329	0	696,329	5.01
5.02	00591	744,383	807,929	1,552,312	-9,784	1,542,528	5.02
5.03	00592	1,069,796	1,114,247	2,184,043	-87,547	2,096,496	5.03
7.00	00700	579,273	1,038,333	1,617,606	100,784	1,718,390	7.00
7.01	00701	21,753	52,692	74,445	0	74,445	7.01
8.00	00800	280,699	209,348	490,047	-91,910	398,137	8.00
9.00	00900	294,522	140,295	434,817	0	434,817	9.00
10.00	01000	384,305	389,862	774,167	0	774,167	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	795,790	23,223	819,013	0	819,013	13.00
14.00	01400	43,357	49,263	92,620	0	92,620	14.00
15.00	01500	268,479	422,363	690,842	0	690,842	15.00
16.00	01600	476,026	147,899	623,925	0	623,925	16.00
17.00	01700	375,267	31,391	406,658	0	406,658	17.00
18.00	01850	287,158	15,761	302,919	0	302,919	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,178,491	500,575	1,679,066	0	1,679,066	30.00
31.00	03100	448,012	148,612	596,624	0	596,624	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,440,579	1,650,526	3,091,105	-681,646	2,409,459	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	1,037,197	1,037,197	0	1,037,197	53.00
54.00	05400	599,496	244,278	843,774	0	843,774	54.00
55.00	05500	229,300	83,209	312,509	0	312,509	55.00
56.00	05600	0	300,157	300,157	0	300,157	56.00
57.00	05700	109,495	212,727	322,222	0	322,222	57.00
58.00	05800	91,866	127,491	219,357	0	219,357	58.00
60.00	06000	739,313	1,085,381	1,824,694	0	1,824,694	60.00
63.00	06300	0	74,570	74,570	0	74,570	63.00
65.00	06500	396,746	38,637	435,383	0	435,383	65.00
66.00	06600	548,152	32,396	580,548	0	580,548	66.00
69.00	06900	43,332	13,004	56,336	0	56,336	69.00
70.00	07000	2,167	569	2,736	0	2,736	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	681,646	681,646	72.00
73.00	07300	0	778,645	778,645	0	778,645	73.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	66,902	48,478	115,380	0	115,380	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	1,134,703	1,134,703	88.00
90.00	09000	1,301,470	98,396	1,399,866	53,253	1,453,119	90.00
90.01	04950	50,652	4,579	55,231	0	55,231	90.01
90.02	09001	1,661,395	282,971	1,944,366	-988,395	955,971	90.02
91.00	09100	853,732	1,965,558	2,819,290	-2,460	2,816,830	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
106.00	10600	0	0	0	0	0	106.00
113.00	11300	0	130,282	130,282	-130,282	0	113.00
118.00		16,220,537	22,704,785	38,925,322	0	38,925,322	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.03	19203	0	0	0	0	0	192.03
194.00	07956	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07950	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07954	434	151,615	152,049	0	152,049	194.06
200.00		16,220,971	22,856,400	39,077,371	0	39,077,371	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141337

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

Worksheet A
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-155,374	1,217,852	1.00
1.01	00101	PERRY PLAZA B&F	0	121,032	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-131,855	1,039,645	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,431,805	4,470,316	4.00
5.01	00590	BUSINESS OFFICE	-1,023	695,306	5.01
5.02	00591	A&G HOSPITAL-ONLY	-6,674	1,535,854	5.02
5.03	00592	A&G SHARED	-295,808	1,800,688	5.03
7.00	00700	OPERATION OF PLANT	0	1,718,390	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	74,445	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	398,137	8.00
9.00	00900	HOUSEKEEPING	0	434,817	9.00
10.00	01000	DIETARY	-192,496	581,671	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-2,750	816,263	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	92,620	14.00
15.00	01500	PHARMACY	0	690,842	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-36	623,889	16.00
17.00	01700	SOCIAL SERVICE	0	406,658	17.00
18.00	01850	PATIENT REGISTRATION	0	302,919	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-354,508	1,324,558	30.00
31.00	03100	INTENSIVE CARE UNIT	0	596,624	31.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-14,480	2,394,979	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-992,893	44,304	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	843,774	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	312,509	55.00
56.00	05600	RADIOISOTOPE	0	300,157	56.00
57.00	05700	CT SCAN	0	322,222	57.00
58.00	05800	MRI	0	219,357	58.00
60.00	06000	LABORATORY	-37,286	1,787,408	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	74,570	63.00
65.00	06500	RESPIRATORY THERAPY	0	435,383	65.00
66.00	06600	PHYSICAL THERAPY	0	580,548	66.00
69.00	06900	ELECTROCARDIOLOGY	0	56,336	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,736	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	681,646	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	778,645	73.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	-27,141	88,239	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC-PRINCETON	0	1,134,703	88.00
90.00	09000	CLINIC	-1,175,369	277,750	90.00
90.01	04950	SLEEP LAB	0	55,231	90.01
90.02	09001	RHC-PRINCETON	-460,998	494,973	90.02
91.00	09100	EMERGENCY	-1,268,282	1,548,548	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
SPECIAL PURPOSE COST CENTERS					
106.00	10600	HEART ACQUISITION	0	0	106.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,548,778	31,376,544	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	RHC-PRINCETON	0	0	192.01
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	192.03
194.00	07956	OTHER NRCC	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	0	194.01
194.02	07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	0	194.03
194.04	07950	DME CLOSED FY15	0	0	194.04
194.05	07955	PERRY PLAZA LEASED	0	0	194.05
194.06	07954	PM PROMPT CARE	0	152,049	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-7,548,778	31,528,593	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	130,282	1.00
	TOTALS		0	130,282	
B - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	46,804	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	44,113	2.00
	TOTALS		0	90,917	
C - EMPLOYEE PHYSICALS					
1.00	A&G SHARED	5.03	0	2,460	1.00
	TOTALS		0	2,460	
D - LAUNDRY UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	100,784	1.00
	TOTALS		0	100,784	
E - MATERIALS MANAGEMENT DIRECTOR					
1.00	A&G SHARED	5.03	910	0	1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	8,874	0	2.00
	TOTALS		9,784	0	
F - PHYSICIAN BENEFITS RECLASS					
1.00	RHC-PRINCETON	88.00	0	79,408	1.00
2.00	CLINIC	90.00	0	53,253	2.00
3.00	RHC-PRINCETON	90.02	0	66,900	3.00
	TOTALS		0	199,561	
G - IMPLANTIBLES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	681,646	1.00
	TOTALS		0	681,646	
H - RHC-PRINCETON					
1.00	RHC-PRINCETON	88.00	901,714	153,581	1.00
	TOTALS		901,714	153,581	
500.00	Grand Total: Increases		911,498	1,359,231	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	130,282	11		1.00
	TOTALS		0	130,282			
B - PROPERTY INSURANCE							
1.00	A&G SHARED	5.03	0	90,917	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	90,917			
C - EMPLOYEE PHYSICALS							
1.00	EMERGENCY	91.00	0	2,460	0		1.00
	TOTALS		0	2,460			
D - LAUNDRY UTILITIES							
1.00	LAUNDRY & LINEN SERVICE	8.00	0	100,784	0		1.00
	TOTALS		0	100,784			
E - MATERIALS MANAGEMENT DIRECTOR							
1.00	A&G HOSPITAL-ONLY	5.02	9,784	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		9,784	0			
F - PHYSICIAN BENEFITS RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	199,561	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	199,561			
G - IMPLANTIBLES RECLASS							
1.00	OPERATING ROOM	50.00	0	681,646	0		1.00
	TOTALS		0	681,646			
H - RHC-PRINCETON							
1.00	RHC-PRINCETON	90.02	901,714	153,581	0		1.00
	TOTALS		901,714	153,581			
500.00	Grand Total: Decreases		911,498	1,359,231			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141337

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

Worksheet A-7
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	607,110	0	0	0	1.00
2.00	Land Improvements	1,356,777	100,421	0	100,421	2.00
3.00	Buildings and Fixtures	38,248,770	742,321	0	742,321	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	17,248,826	1,305,159	0	1,305,159	6.00
7.00	HIT designated Assets	343,365	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,804,848	2,147,901	0	2,147,901	8.00
9.00	Reconciling Items	633,831	0	0	0	182,067
10.00	Total (line 8 minus line 9)	57,171,017	2,147,901	0	2,147,901	-182,067
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	607,110	0			1.00
2.00	Land Improvements	1,457,198	0			2.00
3.00	Buildings and Fixtures	38,991,091	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	18,553,985	0			6.00
7.00	HIT designated Assets	343,365	0			7.00
8.00	Subtotal (sum of lines 1-7)	59,952,749	0			8.00
9.00	Reconciling Items	451,764	0			9.00
10.00	Total (line 8 minus line 9)	59,500,985	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141337

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

Worksheet A-7
Part II
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,196,140	0	0	0	0	1.00
1.01	PERRY PLAZA B&F	121,032	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	1,127,387	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,444,559	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,196,140				1.00
1.01	PERRY PLAZA B&F	0	121,032				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,127,387				2.00
3.00	Total (sum of lines 1-2)	0	2,444,559				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141337

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

Worksheet A-7
Part III
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	41,055,399	0	41,055,399	0.684796	0	1.00
1.01	PERRY PLAZA B&F	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	18,897,350	0	18,897,350	0.315204	0	2.00
3.00	Total (sum of lines 1-2)	59,952,749	0	59,952,749	1.000000	0	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	0	1,184,362	0	1.00
1.01	PERRY PLAZA B&F	0	0	0	121,032	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	995,532	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,300,926	0	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	-13,314	46,804	0	0	1,217,852	1.00
1.01	PERRY PLAZA B&F	0	0	0	0	121,032	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	44,113	0	0	1,039,645	2.00
3.00	Total (sum of lines 1-2)	-13,314	90,917	0	0	2,378,529	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-7,162	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01 Investment income - PERRY PLAZA B&F (chapter 2)		0	PERRY PLAZA B&F	1.01	0	1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-4,330,957			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		0		0.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01 Depreciation - PERRY PLAZA B&F		0	PERRY PLAZA B&F	1.01	0	26.01
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	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

Provider CCN: 141337

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

Worksheet A-8

Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-131,855	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CAFETERIA	B	-168,591	DIETARY	10.00	0	33.00
33.01	DIETICIAN REVENUE (EXP IN DEPT 62)	B	-2,116	DIETARY	10.00	0	33.01
33.02	OUTSIDE CATERING	B	-1,868	DIETARY	10.00	0	33.02
33.03	MEDICAL RECORDS	B	-36	MEDICAL RECORDS & LIBRARY	16.00	0	33.03
33.04	CONTRACT NURSING	B	-2,750	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MISCELLANEOUS	B	-3,372	A&G SHARED	5.03	0	33.05
33.06	MOBILE MEALS	A	-19,921	DIETARY	10.00	0	33.06
33.07	GASB 68	A	-1,697,861	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08			0		0.00	0	33.08
33.11	BILLING & COLLECTIONS	A	-1,023	BUSINESS OFFICE	5.01	0	33.11
33.12	AMORTIZATION EXPENSE	A	-61,783	CAP REL COSTS-BLDG & FIXT	1.00	11	33.12
33.13	TELEPHONE SALARY OFFSET	A	-6,674	A&G HOSPITAL-ONLY	5.02	0	33.13
33.14	TELEPHONE BENEFIT OFFSET	A	-2,083	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	NON-ALLOWABLE MARKETING	A	-246,715	A&G SHARED	5.03	0	33.15
33.16	MARKETING BENEFITS	A	-27,432	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	RENTAL PROPERTY - CAPITAL	A	-11,778	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33.18	2004 BOND INTEREST	A	-10,297	CAP REL COSTS-BLDG & FIXT	1.00	11	33.18
33.21	IHA DUES OFFSET	A	-20,316	A&G SHARED	5.03	0	33.21
33.22	ALCOHOL EXP	A	-60	A&G SHARED	5.03	0	33.22
33.23	PHYSICIAN ON CALL	A	-25,000	A&G SHARED	5.03	0	33.23
33.24	SELF-INSURANCE OFFSET	A	-678,363	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.24
33.25	UNFUNDED OTHER POST EMPLOYMENT BENEF	A	-26,066	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
33.26	SOCIAL ORG. DUES - PRINCETON ROTARY	B	-345	A&G SHARED	5.03	0	33.26
33.27	NON-ALLOWABLE NOTE INTEREST	A	-64,354	CAP REL COSTS-BLDG & FIXT	1.00	11	33.27
34.00			0		0.00	0	34.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,548,778				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: 141337

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

Worksheet A-8-2

Date/Time Prepared:
9/22/2016 8:10 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,745,295	1,268,282	477,013	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	90.00	CLINIC	1,175,369	1,175,369	0	0	0	3.00
4.00	90.02	RHC- PRINCETON	460,998	460,998	0	0	0	4.00
5.00	50.00	OPERATING ROOM	14,480	14,480	0	0	0	5.00
6.00	60.00	LABORATORY	37,286	37,286	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	992,893	992,893	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	27,141	27,141	0	0	0	8.00
9.00	5.03	A&G SHARED	217,111	0	217,111	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	354,508	354,508	0	0	0	10.00
200.00			5,025,081	4,330,957	694,124			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	90.02	RHC- PRINCETON	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	5.03	A&G SHARED	0	0	0	0	0	9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	1,268,282		1.00
2.00	90.00	CLINIC	0	0	0	0		2.00
3.00	90.00	CLINIC	0	0	0	1,175,369		3.00
4.00	90.02	RHC- PRINCETON	0	0	0	460,998		4.00
5.00	50.00	OPERATING ROOM	0	0	0	14,480		5.00
6.00	60.00	LABORATORY	0	0	0	37,286		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	992,893		7.00
8.00	76.97	CARDIAC REHABILITATION	0	0	0	27,141		8.00
9.00	5.03	A&G SHARED	0	0	0	0		9.00
10.00	30.00	ADULTS & PEDIATRICS	0	0	0	354,508		10.00
200.00			0	0	0	4,330,957		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141337

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

Worksheet B
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	PERRY PLAZA B&F	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,217,852	1,217,852			1.00
1.01 00101	PERRY PLAZA B&F	121,032	0	121,032		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,039,645		1,039,645		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,470,316	5,890	0	0	4,476,206
5.01 00590	BUSINESS OFFICE	695,306	26,539	0	0	149,773
5.02 00591	A&G HOSPITAL-ONLY	1,535,854	51,626	748	163,032	236,770
5.03 00592	A&G SHARED	1,800,688	99,919	0	7,864	319,852
7.00 00700	OPERATION OF PLANT	1,718,390	152,349	18,655	20,406	188,433
7.01 00701	PERRY PLAZA PLANT OP	74,445	0	841	75	7,076
8.00 00800	LAUNDRY & LINEN SERVICE	398,137	18,538	23,684	17,980	94,196
9.00 00900	HOUSEKEEPING	434,817	15,655	0	23	95,806
10.00 01000	DIETARY	581,671	34,422	0	16,656	125,012
11.00 01100	CAFETERIA	0	17,113	0	0	0
13.00 01300	NURSING ADMINISTRATION	816,263	16,864	0	0	258,865
14.00 01400	CENTRAL SERVICES & SUPPLY	92,620	12,034	0	3,277	14,104
15.00 01500	PHARMACY	690,842	15,400	0	1,640	87,334
16.00 01600	MEDICAL RECORDS & LIBRARY	623,889	30,539	0	2,286	154,848
17.00 01700	SOCIAL SERVICE	406,658	12,884	0	0	122,072
18.00 01850	PATIENT REGISTRATION	302,919	6,426	0	1,055	93,410
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,324,558	115,032	0	52,793	383,355
31.00 03100	INTENSIVE CARE UNIT	596,624	22,277	0	11,710	145,735
43.00 04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,394,979	157,898	0	173,226	468,608
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	44,304	1,164	0	14,918	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	843,774	31,461	0	38,948	195,012
55.00 05500	RADIOLOGY-THERAPEUTIC	312,509	2,209	0	12,775	74,590
56.00 05600	RADIOISOTOPE	300,157	3,850	0	0	0
57.00 05700	CT SCAN	322,222	0	0	110,320	35,618
58.00 05800	MRI	219,357	8,380	0	271,966	29,883
60.00 06000	LABORATORY	1,787,408	26,258	0	53,057	240,493
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	74,570	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	435,383	16,224	0	4,400	129,059
66.00 06600	PHYSICAL THERAPY	580,548	31,944	0	612	178,310
69.00 06900	ELECTROCARDIOLOGY	56,336	902	0	24,694	14,096
70.00 07000	ELECTROENCEPHALOGRAPHY	2,736	2,236	0	458	705
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	681,646	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	778,645	0	0	0	0
76.00 03140	CARDIOLOGY	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	88,239	9,707	0	5,440	21,763
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC-PRINCETON	1,134,703	25,401	0	3,929	155,671
90.00 09000	CLINIC	277,750	23,310	0	560	58,109
90.01 04950	SLEEP LAB	55,231	5,340	0	4,470	16,477
90.02 09001	RHC-PRINCETON	494,973	21,394	0	3,310	103,316
91.00 09100	EMERGENCY	1,548,548	54,267	0	17,765	277,713
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS						
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
106.00 10600	HEART ACQUISITION	0	0	0	0	0
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,376,544	1,075,452	43,928	1,039,645	4,476,064
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,327	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01 19201	RHC-PRINCETON	0	0	0	0	0
192.03 19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00 07956	OTHER NRCC	0	0	0	0	0
194.01 07951	HOSPITAL LEASED SPACE	0	15,864	0	0	0
194.02 07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	0	0	0
194.03 07953	MOB LEASED SPACE	0	122,209	0	0	0
194.04 07950	DME CLOSED FY15	0	0	0	0	0
194.05 07955	PERRY PLAZA LEASED	0	0	77,104	0	0
194.06 07954	PM PROMPT CARE	152,049	0	0	0	142

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141337

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

Worksheet B
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	PERRY PLAZA B&F	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	31,528,593	1,217,852	121,032	1,039,645	4,476,206	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 141337		Period: From 05/01/2015 To 04/30/2016		Worksheet B Part I Date/Time Prepared: 9/22/2016 8:10 pm	
Cost Center Description			BUSINESS OFFICE	Subtotal	A&G HOSPITAL-ONLY	Subtotal	A&G SHARED	
			5.01	5A.01	5.02	5A.02	5.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	PERRY PLAZA B&F						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE	871,618					5.01
5.02	00591	A&G HOSPITAL-ONLY	0	1,988,030	1,988,030			5.02
5.03	00592	A&G SHARED	0	2,228,323	151,085	2,379,408	2,379,408	5.03
7.00	00700	OPERATION OF PLANT	0	2,098,233	142,264	2,240,497	184,276	7.00
7.01	00701	PERRY PLAZA PLANT OP	0	82,437	5,589	88,026	7,240	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	552,535	37,463	589,998	48,526	8.00
9.00	00900	HOUSEKEEPING	0	546,301	37,040	583,341	47,979	9.00
10.00	01000	DIETARY	0	757,761	51,378	809,139	66,550	10.00
11.00	01100	CAFETERIA	0	17,113	1,160	18,273	1,503	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,091,992	74,039	1,166,031	95,904	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	122,035	8,274	130,309	10,718	14.00
15.00	01500	PHARMACY	0	795,216	53,917	849,133	69,839	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	811,562	55,026	866,588	71,275	16.00
17.00	01700	SOCIAL SERVICE	0	541,614	36,723	578,337	47,567	17.00
18.00	01850	PATIENT REGISTRATION	0	403,810	27,379	431,189	35,464	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,517	1,920,255	130,197	2,050,452	168,646	30.00
31.00	03100	INTENSIVE CARE UNIT	9,718	786,064	53,297	839,361	69,036	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	163,520	3,358,231	227,701	3,585,932	294,936	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,239	69,625	4,721	74,346	6,115	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,856	1,158,051	78,518	1,236,569	101,705	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,285	433,368	29,383	462,751	38,060	55.00
56.00	05600	RADIOISOTOPE	12,137	316,144	21,435	337,579	27,765	56.00
57.00	05700	CT SCAN	100,395	568,555	38,549	607,104	49,933	57.00
58.00	05800	MRI	37,329	566,915	38,438	605,353	49,789	58.00
60.00	06000	LABORATORY	158,462	2,265,678	153,617	2,419,295	198,982	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,951	76,521	5,188	81,709	6,720	63.00
65.00	06500	RESPIRATORY THERAPY	18,002	603,068	40,889	643,957	52,964	65.00
66.00	06600	PHYSICAL THERAPY	38,200	829,614	56,249	885,863	72,860	66.00
69.00	06900	ELECTROCARDIOLOGY	11,159	107,187	7,267	114,454	9,414	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	403	6,538	443	6,981	574	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,866	697,512	47,293	744,805	61,259	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,619	819,264	55,548	874,812	71,952	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,733	129,882	8,806	138,688	11,407	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC-PRINCETON	17,482	1,337,186	90,664	1,427,850	117,438	88.00
90.00	09000	CLINIC	10,402	370,131	25,096	395,227	32,507	90.00
90.01	04950	SLEEP LAB	6,098	87,616	5,941	93,557	7,695	90.01
90.02	09001	RHC-PRINCETON	6,626	629,619	42,689	672,308	55,296	90.02
91.00	09100	EMERGENCY	84,619	1,982,912	134,445	2,117,357	174,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS								
106.00	10600	HEART ACQUISITION	0	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	871,618	31,156,898	1,977,711	31,146,579	2,366,042	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,327	0	4,327	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	RHC-PRINCETON	0	0	0	0	0	192.01
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0	192.03
194.00	07956	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	15,864	0	15,864	0	194.01
194.02	07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	122,209	0	122,209	0	194.03
194.04	07950	DME CLOSED FY15	0	0	0	0	0	194.04
194.05	07955	PERRY PLAZA LEASED	0	77,104	0	77,104	0	194.05
194.06	07954	PM PROMPT CARE	0	152,191	10,319	162,510	13,366	194.06
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	871,618	31,528,593	1,988,030	31,528,593	2,379,408	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part I Date/Time Prepared: 9/22/2016 8:10 pm			
Cost Center Description		OPERATION OF PLANT 7.00	PERRY PLAZA PLANT OP 7.01	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT	2,424,773				7.00
7.01	00701	PERRY PLAZA PLANT OP	0	95,266			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	50,991	22,386	711,901		8.00
9.00	00900	HOUSEKEEPING	43,062	0	10,772	685,154	9.00
10.00	01000	DIETARY	94,682	0	0	18,617	988,988
11.00	01100	CAFETERIA	47,071	0	611	0	469,936
13.00	01300	NURSING ADMINISTRATION	46,388	0	0	9,308	6,767
14.00	01400	CENTRAL SERVICES & SUPPLY	33,101	0	257	17,637	0
15.00	01500	PHARMACY	42,361	0	0	9,798	0
16.00	01600	MEDICAL RECORDS & LIBRARY	84,002	0	0	7,349	1,798
17.00	01700	SOCIAL SERVICE	35,438	0	0	4,654	946
18.00	01850	PATIENT REGISTRATION	17,674	0	0	5,879	5,063
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	316,411	0	37,737	130,319	388,403
31.00	03100	INTENSIVE CARE UNIT	61,276	0	7,509	16,902	52,667
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	434,327	0	28,473	152,856	33,124
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	3,200	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,537	0	3,578	15,922	1,372
55.00	05500	RADIOLOGY-THERAPEUTIC	6,077	0	2,941	0	0
56.00	05600	RADIOISOTOPE	10,590	0	731	0	95
57.00	05700	CT SCAN	0	0	3,072	2,695	0
58.00	05800	MRI	23,050	0	1,881	5,879	0
60.00	06000	LABORATORY	72,225	0	24	21,557	2,129
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	44,626	0	0	11,758	0
66.00	06600	PHYSICAL THERAPY	87,868	0	8,541	26,211	0
69.00	06900	ELECTROCARDIOLOGY	2,481	0	16	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	6,149	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	26,700	0	110	0	47
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC-PRINCETON	69,870	0	227	17,147	1,514
90.00	09000	CLINIC	64,116	0	1,152	14,698	2,082
90.01	04950	SLEEP LAB	14,690	0	0	15,432	994
90.02	09001	RHC-PRINCETON	58,848	0	192	14,453	1,278
91.00	09100	EMERGENCY	149,269	0	19,834	87,696	20,773
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
106.00	10600	HEART ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,033,080	22,386	127,658	606,767	988,988
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,903	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RHC-PRINCETON	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	584,243	0	0
194.00	07956	OTHER NRCC	0	0	0	0	0
194.01	07951	HOSPITAL LEASED SPACE	43,637	0	0	0	0
194.02	07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	0	0	0
194.03	07953	MOB LEASED SPACE	336,153	0	0	78,387	0
194.04	07950	DME CLOSED FY15	0	0	0	0	0
194.05	07955	PERRY PLAZA LEASED	0	72,880	0	0	0
194.06	07954	PM PROMPT CARE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,424,773	95,266	711,901	685,154	988,988

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141337

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

Worksheet B
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00590						5.01
5.02	00591						5.02
5.03	00592						5.03
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	537,394					11.00
13.00	01300	26,853	1,351,251				13.00
14.00	01400	4,938	25,930	222,890			14.00
15.00	01500	14,847	0	1,203	987,181		15.00
16.00	01600	44,743	0	0	0	1,075,755	16.00
17.00	01700	23,031	0	0	0	0	17.00
18.00	01850	22,355	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,710	496,552	10,439	108	54,944	30.00
31.00	03100	14,272	123,952	1,562	2	11,995	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	75,587	418,266	99,412	1,789	201,802	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	3,103	27	11,403	53.00
54.00	05400	25,060	0	0	0	60,300	54.00
55.00	05500	12,310	0	0	0	38,613	55.00
56.00	05600	0	0	8	124,265	14,979	56.00
57.00	05700	5,817	0	0	0	123,910	57.00
58.00	05800	4,836	0	0	0	46,072	58.00
60.00	06000	38,588	0	0	0	195,578	60.00
63.00	06300	0	0	0	0	2,408	63.00
65.00	06500	14,576	0	1,682	4,413	22,219	65.00
66.00	06600	29,998	0	1,000	1,588	47,148	66.00
69.00	06900	3,855	0	213	0	13,773	69.00
70.00	07000	0	0	0	0	497	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	88,971	0	19,582	72.00
73.00	07300	0	0	0	848,969	50,133	73.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	4,735	0	1,153	0	5,841	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	43,019	0	2,323	2,960	21,577	88.00
90.00	09000	17,958	0	629	2	12,839	90.00
90.01	04950	169	0	512	0	7,526	90.01
90.02	09001	36,221	0	1,957	2,494	8,178	90.02
91.00	09100	28,916	286,551	8,723	394	104,438	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
106.00	10600	0	0	0	0	0	106.00
113.00	11300						113.00
118.00		537,394	1,351,251	222,890	987,011	1,075,755	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.03	19203	0	0	0	0	0	192.03
194.00	07956	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07950	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07954	0	0	0	170	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		537,394	1,351,251	222,890	987,181	1,075,755	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141337

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

Worksheet B
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		PATIENT REGISTRATION				
	17.00	18.00	24.00	25.00	26.00	
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	689,973	517,624	31,528,593	0	31,528,593	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part II Date/Time Prepared: 9/22/2016 8:10 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	PERRY PLAZA B&F	MVBLE EQUIP		
		0	1.00	2.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	PERRY PLAZA B&F					1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,890	0	0	4.00
5.01 00590	BUSINESS OFFICE	0	26,539	0	0	5.01
5.02 00591	A&G HOSPITAL-ONLY	0	51,626	748	163,032	5.02
5.03 00592	A&G SHARED	0	99,919	0	7,864	5.03
7.00 00700	OPERATION OF PLANT	0	152,349	18,655	20,406	7.00
7.01 00701	PERRY PLAZA PLANT OP	0	0	841	75	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	0	18,538	23,684	17,980	8.00
9.00 00900	HOUSEKEEPING	0	15,655	0	23	9.00
10.00 01000	DIETARY	0	34,422	0	16,656	10.00
11.00 01100	CAFETERIA	0	17,113	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	16,864	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	12,034	0	3,277	14.00
15.00 01500	PHARMACY	0	15,400	0	1,640	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	30,539	0	2,286	16.00
17.00 01700	SOCIAL SERVICE	0	12,884	0	0	17.00
18.00 01850	PATIENT REGISTRATION	0	6,426	0	1,055	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	115,032	0	52,793	30.00
31.00 03100	INTENSIVE CARE UNIT	0	22,277	0	11,710	31.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	157,898	0	173,226	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	1,164	0	14,918	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	31,461	0	38,948	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	2,209	0	12,775	55.00
56.00 05600	RADIOISOTOPE	0	3,850	0	0	56.00
57.00 05700	CT SCAN	0	0	0	110,320	57.00
58.00 05800	MRI	0	8,380	0	271,966	58.00
60.00 06000	LABORATORY	0	26,258	0	53,057	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 06500	RESPIRATORY THERAPY	0	16,224	0	4,400	65.00
66.00 06600	PHYSICAL THERAPY	0	31,944	0	612	66.00
69.00 06900	ELECTROCARDIOLOGY	0	902	0	24,694	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	2,236	0	458	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00 03140	CARDIOLOGY	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	9,707	0	5,440	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RHC-PRINCETON	0	25,401	0	3,929	88.00
90.00 09000	CLINIC	0	23,310	0	560	90.00
90.01 04950	SLEEP LAB	0	5,340	0	4,470	90.01
90.02 09001	RHC-PRINCETON	0	21,394	0	3,310	90.02
91.00 09100	EMERGENCY	0	54,267	0	17,765	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS						
106.00 10600	HEART ACQUISITION	0	0	0	0	106.00
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,075,452	43,928	1,039,645	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,327	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	RHC-PRINCETON	0	0	0	0	192.01
192.03 19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	192.03
194.00 07956	OTHER NRCC	0	0	0	0	194.00
194.01 07951	HOSPITAL LEASED SPACE	0	15,864	0	0	194.01
194.02 07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	0	0	194.02
194.03 07953	MOB LEASED SPACE	0	122,209	0	0	194.03
194.04 07950	DME CLOSED FY15	0	0	0	0	194.04
194.05 07955	PERRY PLAZA LEASED	0	0	77,104	0	194.05
194.06 07954	PM PROMPT CARE	0	0	0	0	194.06
200.00	Cross Foot Adjustments					200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141337

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

Worksheet B
Part II
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	PERRY PLAZA B&F	MVBLE EQUIP		
			1.00	1.01	2.00		
201.00	Negative Cost Centers	0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	0	1,217,852	121,032	1,039,645	2,378,529	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part II Date/Time Prepared: 9/22/2016 8:10 pm
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	A&G HOSPITAL-ONLY	A&G SHARED	OPERATION OF PLANT	
		4.00	5.01	5.02	5.03	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,890				4.00
5.01	00590	BUSINESS OFFICE	197	26,736			5.01
5.02	00591	A&G HOSPITAL-ONLY	312	0	215,718		5.02
5.03	00592	A&G SHARED	421	0	16,394	124,598	5.03
7.00	00700	OPERATION OF PLANT	248	0	15,437	9,650	216,745
7.01	00701	PERRY PLAZA PLANT OP	9	0	606	379	0
8.00	00800	LAUNDRY & LINEN SERVICE	124	0	4,065	2,541	4,558
9.00	00900	HOUSEKEEPING	126	0	4,019	2,512	3,849
10.00	01000	DIETARY	164	0	5,575	3,485	8,463
11.00	01100	CAFETERIA	0	0	126	79	4,208
13.00	01300	NURSING ADMINISTRATION	341	0	8,034	5,022	4,147
14.00	01400	CENTRAL SERVICES & SUPPLY	19	0	898	561	2,959
15.00	01500	PHARMACY	115	0	5,850	3,657	3,787
16.00	01600	MEDICAL RECORDS & LIBRARY	204	0	5,971	3,732	7,509
17.00	01700	SOCIAL SERVICE	161	0	3,985	2,491	3,168
18.00	01850	PATIENT REGISTRATION	123	0	2,971	1,857	1,580
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	504	1,365	14,127	8,831	28,283
31.00	03100	INTENSIVE CARE UNIT	192	298	5,783	3,615	5,477
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	615	5,027	24,707	15,444	38,822
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	283	512	320	286
54.00	05400	RADIOLOGY-DIAGNOSTIC	257	1,498	8,520	5,326	7,735
55.00	05500	RADIOLOGY-THERAPEUTIC	98	959	3,188	1,993	543
56.00	05600	RADIOISOTOPE	0	372	2,326	1,454	947
57.00	05700	CT SCAN	47	3,078	4,183	2,615	0
58.00	05800	MRI	39	1,145	4,171	2,607	2,060
60.00	06000	LABORATORY	316	4,859	16,669	10,420	6,456
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	60	563	352	0
65.00	06500	RESPIRATORY THERAPY	170	552	4,437	2,774	3,989
66.00	06600	PHYSICAL THERAPY	235	1,171	6,103	3,815	7,854
69.00	06900	ELECTROCARDIOLOGY	19	342	789	493	222
70.00	07000	ELECTROENCEPHALOGRAPHY	1	12	48	30	550
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	486	5,132	3,208	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,245	6,027	3,768	0
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	29	145	956	597	2,387
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC-PRINCETON	205	536	9,838	6,150	6,246
90.00	09000	CLINIC	76	319	2,723	1,702	5,731
90.01	04950	SLEEP LAB	22	187	645	403	1,313
90.02	09001	RHC-PRINCETON	136	203	4,632	2,896	5,260
91.00	09100	EMERGENCY	365	2,594	14,588	9,119	13,343
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
106.00	10600	HEART ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,890	26,736	214,598	123,898	181,732
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	1,064
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RHC-PRINCETON	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00	07956	OTHER NRCC	0	0	0	0	0
194.01	07951	HOSPITAL LEASED SPACE	0	0	0	0	3,901
194.02	07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	0	0	0
194.03	07953	MOB LEASED SPACE	0	0	0	0	30,048
194.04	07950	DME CLOSED FY15	0	0	0	0	0
194.05	07955	PERRY PLAZA LEASED	0	0	0	0	0
194.06	07954	PM PROMPT CARE	0	0	1,120	700	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	5,890	26,736	215,718	124,598	216,745

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part II Date/Time Prepared: 9/22/2016 8:10 pm			
Cost Center Description		PERRY PLAZA PLANT OP	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
8.00	00800	1,910	71,939				8.00
9.00	00900	449	1,089	27,273			9.00
10.00	01000	0	0	741	69,506		10.00
11.00	01100	0	62	0	33,027	54,615	11.00
13.00	01300	0	0	371	476	2,729	13.00
14.00	01400	0	26	702	0	502	14.00
15.00	01500	0	0	390	0	1,509	15.00
16.00	01600	0	0	293	126	4,547	16.00
17.00	01700	0	0	185	67	2,341	17.00
18.00	01850	0	0	234	356	2,272	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	3,813	5,187	27,297	4,544	30.00
31.00	03100	0	759	673	3,701	1,450	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,877	6,085	2,328	7,681	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	362	634	96	2,547	54.00
55.00	05500	0	297	0	0	1,251	55.00
56.00	05600	0	74	0	7	0	56.00
57.00	05700	0	310	107	0	591	57.00
58.00	05800	0	190	234	0	492	58.00
60.00	06000	0	2	858	150	3,922	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	0	468	0	1,481	65.00
66.00	06600	0	863	1,043	0	3,049	66.00
69.00	06900	0	2	0	0	392	69.00
70.00	07000	0	0	0	0	0	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	0	73.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	0	11	0	3	481	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	23	683	106	4,372	88.00
90.00	09000	0	116	585	146	1,825	90.00
90.01	04950	0	0	614	70	17	90.01
90.02	09001	0	19	575	90	3,681	90.02
91.00	09100	0	2,004	3,491	1,460	2,939	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
106.00	10600	0	0	0	0	0	106.00
113.00	11300	0	0	0	0	0	113.00
118.00		449	12,899	24,153	69,506	54,615	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.03	19203	0	59,040	0	0	0	192.03
194.00	07956	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	3,120	0	0	194.03
194.04	07950	0	0	0	0	0	194.04
194.05	07955	1,461	0	0	0	0	194.05
194.06	07954	0	0	0	0	0	194.06
200.00							200.00
201.00							201.00
202.00		1,910	71,939	27,273	69,506	54,615	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet B Part II Date/Time Prepared: 9/22/2016 8:10 pm
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00590						5.01
5.02	00591						5.02
5.03	00592						5.03
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	37,984					13.00
14.00	01400	729	21,707				14.00
15.00	01500	0	117	32,465			15.00
16.00	01600	0	0	0	55,207		16.00
17.00	01700	0	0	0	0	25,282	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,958	1,017	4	2,820	22,944	30.00
31.00	03100	3,484	152	0	616	2,338	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	11,758	9,681	59	10,346	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	302	1	585	0	53.00
54.00	05400	0	0	0	3,095	0	54.00
55.00	05500	0	0	0	1,982	0	55.00
56.00	05600	0	1	4,087	769	0	56.00
57.00	05700	0	0	0	6,360	0	57.00
58.00	05800	0	0	0	2,365	0	58.00
60.00	06000	0	0	0	10,039	0	60.00
63.00	06300	0	0	0	124	0	63.00
65.00	06500	0	164	145	1,141	0	65.00
66.00	06600	0	97	52	2,420	0	66.00
69.00	06900	0	21	0	707	0	69.00
70.00	07000	0	0	0	26	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	8,665	0	1,005	0	72.00
73.00	07300	0	0	27,919	2,573	0	73.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	0	112	0	300	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	226	97	1,108	0	88.00
90.00	09000	0	61	0	659	0	90.00
90.01	04950	0	50	0	386	0	90.01
90.02	09001	0	191	82	420	0	90.02
91.00	09100	8,055	850	13	5,361	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
106.00	10600	0	0	0	0	0	106.00
113.00	11300	0	0	0	0	0	113.00
118.00		37,984	21,707	32,459	55,207	25,282	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.03	19203	0	0	0	0	0	192.03
194.00	07956	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07950	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07954	0	0	6	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		37,984	21,707	32,465	55,207	25,282	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141337

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

Worksheet B
Part II
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		PATIENT REGISTRATION					
		18.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY					5.02
5.03	00592	A&G SHARED					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PERRY PLAZA PLANT OP					7.01
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
17.00	01700	SOCIAL SERVICE					17.00
18.00	01850	PATIENT REGISTRATION	16,874				18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	898	303,417	0	303,417	30.00
31.00	03100	INTENSIVE CARE UNIT	196	62,721	0	62,721	31.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,290	469,844	0	469,844	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	186	18,557	0	18,557	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	985	101,464	0	101,464	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	631	25,926	0	25,926	55.00
56.00	05600	RADIOISOTOPE	245	14,132	0	14,132	56.00
57.00	05700	CT SCAN	2,025	129,636	0	129,636	57.00
58.00	05800	MRI	753	294,402	0	294,402	58.00
60.00	06000	LABORATORY	3,196	136,202	0	136,202	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	39	1,138	0	1,138	63.00
65.00	06500	RESPIRATORY THERAPY	363	36,308	0	36,308	65.00
66.00	06600	PHYSICAL THERAPY	770	60,028	0	60,028	66.00
69.00	06900	ELECTROCARDIOLOGY	225	28,808	0	28,808	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8	3,369	0	3,369	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	320	18,816	0	18,816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	819	42,351	0	42,351	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	95	20,263	0	20,263	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC-PRINCETON	0	58,920	0	58,920	88.00
90.00	09000	CLINIC	0	37,813	0	37,813	90.00
90.01	04950	SLEEP LAB	123	13,640	0	13,640	90.01
90.02	09001	RHC-PRINCETON	0	42,889	0	42,889	90.02
91.00	09100	EMERGENCY	1,707	137,921	0	137,921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
106.00	10600	HEART ACQUISITION	0	0	0	0	106.00
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,874	2,058,565	0	2,058,565	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,391	0	5,391	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	RHC-PRINCETON	0	0	0	0	192.01
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	59,040	0	59,040	192.03
194.00	07956	OTHER NRCC	0	0	0	0	194.00
194.01	07951	HOSPITAL LEASED SPACE	0	19,765	0	19,765	194.01
194.02	07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	0	0	194.02
194.03	07953	MOB LEASED SPACE	0	155,377	0	155,377	194.03
194.04	07950	DME CLOSED FY15	0	0	0	0	194.04
194.05	07955	PERRY PLAZA LEASED	0	78,565	0	78,565	194.05
194.06	07954	PM PROMPT CARE	0	1,826	0	1,826	194.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141337

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

Worksheet B
Part II
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		OTHER GENERAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		PATIENT REGISTRATION					
		18.00	24.00	25.00	26.00		
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	16,874	2,378,529	0	2,378,529		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1

Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVENUE)	
		BLDG & FIXT (SQUARE FEET)	PERRY PLAZA B&F (PLAZA SQRT)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	186,312				1.00
1.01	00101	PERRY PLAZA B&F	0	37,714			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			995,532		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	901	0	0	13,760,543	4.00
5.01	00590	BUSINESS OFFICE	4,060	0	0	460,426	70,884,126
5.02	00591	A&G HOSPITAL-ONLY	7,898	233	156,114	727,867	0
5.03	00592	A&G SHARED	15,286	0	7,530	983,275	0
7.00	00700	OPERATION OF PLANT	23,307	5,813	19,540	579,273	0
7.01	00701	PERRY PLAZA PLANT OP	0	262	72	21,753	0
8.00	00800	LAUNDRY & LINEN SERVICE	2,836	7,380	17,217	289,573	0
9.00	00900	HOUSEKEEPING	2,395	0	22	294,522	0
10.00	01000	DIETARY	5,266	0	15,949	384,305	0
11.00	01100	CAFETERIA	2,618	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	2,580	0	0	795,790	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,841	0	3,138	43,357	0
15.00	01500	PHARMACY	2,356	0	1,570	268,479	0
16.00	01600	MEDICAL RECORDS & LIBRARY	4,672	0	2,189	476,026	0
17.00	01700	SOCIAL SERVICE	1,971	0	0	375,267	0
18.00	01850	PATIENT REGISTRATION	983	0	1,010	287,158	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,598	0	50,553	1,178,491	3,620,438
31.00	03100	INTENSIVE CARE UNIT	3,408	0	11,213	448,012	790,365
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,156	0	165,876	1,440,579	13,296,513
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	178	0	14,285	0	751,381
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,813	0	37,295	599,496	3,973,361
55.00	05500	RADIOLOGY-THERAPEUTIC	338	0	12,233	229,300	2,544,324
56.00	05600	RADIOISOTOPE	589	0	0	0	987,035
57.00	05700	CT SCAN	0	0	105,639	109,495	8,164,837
58.00	05800	MRI	1,282	0	260,429	91,866	3,035,845
60.00	06000	LABORATORY	4,017	0	50,806	739,313	12,887,314
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	158,674
65.00	06500	RESPIRATORY THERAPY	2,482	0	4,213	396,746	1,464,062
66.00	06600	PHYSICAL THERAPY	4,887	0	586	548,152	3,106,724
69.00	06900	ELECTROCARDIOLOGY	138	0	23,646	43,332	907,519
70.00	07000	ELECTROENCEPHALOGRAPHY	342	0	439	2,167	32,769
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,290,306
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,303,461
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	1,485	0	5,209	66,902	384,893
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC-PRINCETON	3,886	0	3,762	478,556	1,421,762
90.00	09000	CLINIC	3,566	0	536	178,636	845,978
90.01	04950	SLEEP LAB	817	0	4,280	50,652	495,899
90.02	09001	RHC- PRINCETON	3,273	0	3,170	317,610	538,875
91.00	09100	EMERGENCY	8,302	0	17,011	853,732	6,881,791
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
106.00	10600	HEART ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	164,527	13,688	995,532	13,760,108	70,884,126
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	662	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RHC-PRINCETON	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00	07956	OTHER NRCC	0	0	0	0	0
194.01	07951	HOSPITAL LEASED SPACE	2,427	0	0	0	0
194.02	07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	0	0	0
194.03	07953	MOB LEASED SPACE	18,696	0	0	0	0
194.04	07950	DME CLOSED FY15	0	0	0	0	0
194.05	07955	PERRY PLAZA LEASED	0	24,026	0	0	0
194.06	07954	PM PROMPT CARE	0	0	0	435	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE (GROSS REVENUE)	
		BLDG & FIXT (SQUARE FEET)	PERRY PLAZA B&F (PLAZA SQRT)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00			
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,217,852	121,032	1,039,645	4,476,206	871,618	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.536627	3.209206	1.044311	0.325293	0.012296	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				5,890	26,736	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000428	0.000377	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1

Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		Reconciliation	A&G HOSPITAL-ONLY (ACCUM. COST)	Reconciliation	A&G SHARED (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	PERRY PLAZA B&F					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE					5.01
5.02	00591	A&G HOSPITAL-ONLY	-1,988,030	29,321,059			5.02
5.03	00592	A&G SHARED	0	2,228,323	-2,379,408	28,929,681	5.03
7.00	00700	OPERATION OF PLANT	0	2,098,233	0	2,240,497	134,860
7.01	00701	PERRY PLAZA PLANT OP	0	82,437	0	88,026	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	552,535	0	589,998	2,836
9.00	00900	HOUSEKEEPING	0	546,301	0	583,341	2,395
10.00	01000	DIETARY	0	757,761	0	809,139	5,266
11.00	01100	CAFETERIA	0	17,113	0	18,273	2,618
13.00	01300	NURSING ADMINISTRATION	0	1,091,992	0	1,166,031	2,580
14.00	01400	CENTRAL SERVICES & SUPPLY	0	122,035	0	130,309	1,841
15.00	01500	PHARMACY	0	795,216	0	849,133	2,356
16.00	01600	MEDICAL RECORDS & LIBRARY	0	811,562	0	866,588	4,672
17.00	01700	SOCIAL SERVICE	0	541,614	0	578,337	1,971
18.00	01850	PATIENT REGISTRATION	0	403,810	0	431,189	983
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,920,255	0	2,050,452	17,598
31.00	03100	INTENSIVE CARE UNIT	0	786,064	0	839,361	3,408
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	3,358,231	0	3,585,932	24,156
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	69,625	0	74,346	178
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,158,051	0	1,236,569	4,813
55.00	05500	RADIOLOGY-THERAPEUTIC	0	433,368	0	462,751	338
56.00	05600	RADIOISOTOPE	0	316,144	0	337,579	589
57.00	05700	CT SCAN	0	568,555	0	607,104	0
58.00	05800	MRI	0	566,915	0	605,353	1,282
60.00	06000	LABORATORY	0	2,265,678	0	2,419,295	4,017
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	76,521	0	81,709	0
65.00	06500	RESPIRATORY THERAPY	0	603,068	0	643,957	2,482
66.00	06600	PHYSICAL THERAPY	0	829,614	0	885,863	4,887
69.00	06900	ELECTROCARDIOLOGY	0	107,187	0	114,454	138
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,538	0	6,981	342
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	697,512	0	744,805	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	819,264	0	874,812	0
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	129,882	0	138,688	1,485
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RHC-PRINCETON	0	1,337,186	0	1,427,850	3,886
90.00	09000	CLINIC	0	370,131	0	395,227	3,566
90.01	04950	SLEEP LAB	0	87,616	0	93,557	817
90.02	09001	RHC-PRINCETON	0	629,619	0	672,308	3,273
91.00	09100	EMERGENCY	0	1,982,912	0	2,117,357	8,302
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
106.00	10600	HEART ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,988,030	29,168,868	-2,379,408	28,767,171	113,075
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-4,327	0	-4,327	0	662
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RHC-PRINCETON	0	0	0	0	0
192.03	19203	OUTSIDE CONTRACT LAUNDRY	0	0	0	0	0
194.00	07956	OTHER NRCC	0	0	0	0	0
194.01	07951	HOSPITAL LEASED SPACE	-15,864	0	-15,864	0	2,427
194.02	07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	0	0	0	0	0
194.03	07953	MOB LEASED SPACE	-122,209	0	-122,209	0	18,696
194.04	07950	DME CLOSED FY15	0	0	0	0	0
194.05	07955	PERRY PLAZA LEASED	-77,104	0	-77,104	0	0
194.06	07954	PM PROMPT CARE	0	152,191	0	162,510	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		1,988,030		2,379,408	2,424,773

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 141337		Period: From 05/01/2015 To 04/30/2016		Worksheet B-1 Date/Time Prepared: 9/22/2016 8:10 pm	
Cost Center Description		Reconciliation	A&G HOSPITAL-ONLY (ACCUM. COST)	Reconciliation	A&G SHARED (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	7.00	
203.00	Unit cost multiplier (Wkst. B, Part I)		0.067802		0.082248	17,979,927	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		215,718		124,598	216,745	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.007357		0.004307	1,607,185	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1

Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		PERRY PLAZA PLANT OP (PLAZA SQ FT)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERV ED)	
		7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00590						5.01
5.02	00591						5.02
5.03	00592						5.03
7.00	00700						7.00
7.01	00701	31,406					7.01
8.00	00800	7,380	1,059,437				8.00
9.00	00900	0	16,031	2,797			9.00
10.00	01000	0	0	76	20,900		10.00
11.00	01100	0	909	0	9,931	15,890	11.00
13.00	01300	0	0	38	143	794	13.00
14.00	01400	0	382	72	0	146	14.00
15.00	01500	0	0	40	0	439	15.00
16.00	01600	0	0	30	38	1,323	16.00
17.00	01700	0	0	19	20	681	17.00
18.00	01850	0	0	24	107	661	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	56,160	532	8,208	1,322	30.00
31.00	03100	0	11,174	69	1,113	422	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	42,373	624	700	2,235	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	5,324	65	29	741	54.00
55.00	05500	0	4,377	0	0	364	55.00
56.00	05600	0	1,088	0	2	0	56.00
57.00	05700	0	4,572	11	0	172	57.00
58.00	05800	0	2,800	24	0	143	58.00
60.00	06000	0	35	88	45	1,141	60.00
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	0	48	0	431	65.00
66.00	06600	0	12,711	107	0	887	66.00
69.00	06900	0	24	0	0	114	69.00
70.00	07000	0	0	0	0	0	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	0	73.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	0	163	0	1	140	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	338	70	32	1,272	88.00
90.00	09000	0	1,714	60	44	531	90.00
90.01	04950	0	0	63	21	5	90.01
90.02	09001	0	285	59	27	1,071	90.02
91.00	09100	0	29,517	358	439	855	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
106.00	10600	0	0	0	0	0	106.00
113.00	11300	0	0	0	0	0	113.00
118.00		7,380	189,977	2,477	20,900	15,890	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.03	19203	0	869,460	0	0	0	192.03
194.00	07956	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	320	0	0	194.03
194.04	07950	0	0	0	0	0	194.04
194.05	07955	24,026	0	0	0	0	194.05
194.06	07954	0	0	0	0	0	194.06
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		PERRY PLAZA PLANT OP (PLAZA SQ FT)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)	
		7.01	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	95,266	711,901	685,154	988,988	537,394	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.033369	0.671962	244.960315	47.320000	33.819635	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,910	71,939	27,273	69,506	54,615	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.060816	0.067903	9.750804	3.325646	3.437067	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1

Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	00590						5.01
5.02	00591						5.02
5.03	00592						5.03
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	16,363					13.00
14.00	01400	314	1,707,650				14.00
15.00	01500	0	9,215	905,408			15.00
16.00	01600	0	0	0	70,884,126		16.00
17.00	01700	0	0	0	0	3,050	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,013	79,975	99	3,620,438	2,768	30.00
31.00	03100	1,501	11,964	2	790,365	282	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,065	761,653	1,641	13,296,513	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	23,770	25	751,381	0	53.00
54.00	05400	0	0	0	3,973,361	0	54.00
55.00	05500	0	0	0	2,544,324	0	55.00
56.00	05600	0	63	113,972	987,035	0	56.00
57.00	05700	0	0	0	8,164,837	0	57.00
58.00	05800	0	0	0	3,035,845	0	58.00
60.00	06000	0	0	0	12,887,314	0	60.00
63.00	06300	0	0	0	158,674	0	63.00
65.00	06500	0	12,884	4,047	1,464,062	0	65.00
66.00	06600	0	7,658	1,456	3,106,724	0	66.00
69.00	06900	0	1,632	0	907,519	0	69.00
70.00	07000	0	0	0	32,769	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	681,646	0	1,290,306	0	72.00
73.00	07300	0	0	778,645	3,303,461	0	73.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	0	8,832	0	384,893	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	17,797	2,715	1,421,762	0	88.00
90.00	09000	0	4,816	2	845,978	0	90.00
90.01	04950	0	3,919	0	495,899	0	90.01
90.02	09001	0	14,993	2,287	538,875	0	90.02
91.00	09100	3,470	66,833	361	6,881,791	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
106.00	10600	0	0	0	0	0	106.00
113.00	11300						113.00
118.00		16,363	1,707,650	905,252	70,884,126	3,050	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.03	19203	0	0	0	0	0	192.03
194.00	07956	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07950	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07954	0	0	156	0	0	194.06
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1

Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,351,251	222,890	987,181	1,075,755	689,973	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	82.579661	0.130524	1.090316	0.015176	226.220656	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	37,984	21,707	32,465	55,207	25,282	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.321335	0.012712	0.035857	0.000779	8.289180	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		OTHER GENERAL SERVICE PATIENT REGISTRATION (GROSS REVENUE)	18.00
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	PERRY PLAZA B&F	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	BUSINESS OFFICE	5.01
5.02	00591	A&G HOSPITAL-ONLY	5.02
5.03	00592	A&G SHARED	5.03
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	PERRY PLAZA PLANT OP	7.01
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
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	PATIENT REGISTRATION	18.00
		68,077,511	
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
		3,620,438	
		790,365	
		0	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03140	CARDIOLOGY	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
		13,296,513	
		0	
		751,381	
		3,973,361	
		2,544,324	
		987,035	
		8,164,837	
		3,035,845	
		12,887,314	
		158,674	
		1,464,062	
		3,106,724	
		907,519	
		32,769	
		0	
		1,290,306	
		3,303,461	
		0	
		384,893	
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RHC-PRINCETON	88.00
90.00	09000	CLINIC	90.00
90.01	04950	SLEEP LAB	90.01
90.02	09001	RHC-PRINCETON	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
		0	
		495,899	
		0	
		6,881,791	
OTHER REIMBURSABLE COST CENTERS			
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	97.00
		0	
SPECIAL PURPOSE COST CENTERS			
106.00	10600	HEART ACQUISITION	106.00
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		68,077,511	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	RHC-PRINCETON	192.01
192.03	19203	OUTSIDE CONTRACT LAUNDRY	192.03
194.00	07956	OTHER NRCC	194.00
194.01	07951	HOSPITAL LEASED SPACE	194.01
194.02	07952	ORTHO CLINIC - PB IN FY14 ON LINE 9	194.02
194.03	07953	MOB LEASED SPACE	194.03
194.04	07950	DME CLOSED FY15	194.04
194.05	07955	PERRY PLAZA LEASED	194.05
194.06	07954	PM PROMPT CARE	194.06
200.00		Cross Foot Adjustments	200.00
		0	
		0	
		0	
		0	
		0	
		0	
		0	
		0	
		0	
		0	
		0	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141337

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

Worksheet B-1
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		OTHER GENERAL SERVICE		
		PATIENT REGISTRATION (GROSS REVENUE)		
		18.00		
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	517,624		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.007603		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	16,874		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000248		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141337

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

Worksheet C
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

		Title XVIII		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,352,426		4,352,426	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,268,337		1,268,337	0	0	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,427,632		5,427,632	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	103,907		103,907	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,561,252		1,561,252	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	580,096		580,096	0	0	55.00
56.00	05600	RADIOISOTOPE	523,516		523,516	0	0	56.00
57.00	05700	CT SCAN	854,608		854,608	0	0	57.00
58.00	05800	MRI	759,942		759,942	0	0	58.00
60.00	06000	LABORATORY	3,046,360		3,046,360	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	92,043		92,043	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	807,326	0	807,326	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,184,697	0	1,184,697	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	151,106		151,106	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,450		14,450	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	924,427		924,427	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870,982		1,870,982	0	0	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	191,607		191,607	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC-PRINCETON	1,703,925		1,703,925	0	0	88.00
90.00	09000	CLINIC	541,210		541,210	0	0	90.00
90.01	04950	SLEEP LAB	144,345		144,345	0	0	90.01
90.02	09001	RHC-PRINCETON	851,225		851,225	0	0	90.02
91.00	09100	EMERGENCY	3,050,421		3,050,421	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	525,149		525,149	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
SPECIAL PURPOSE COST CENTERS								
106.00	10600	HEART ACQUISITION	0		0		0	106.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,530,989	0	30,530,989	0	0	200.00
201.00		Less Observation Beds	525,149		525,149			201.00
202.00		Total (see instructions)	30,005,840	0	30,005,840	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Prepared: 9/22/2016 8:10 pm
		Title XVII	Hospital	Cost

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	3,084,050		3,084,050	30.00
31.00	03100	INTENSIVE CARE UNIT	790,365		790,365	31.00
43.00	04300	NURSERY	0		0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,525,007	10,771,506	13,296,513	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	311,039	440,342	751,381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,928	3,761,433	3,973,361	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	193,506	2,350,818	2,544,324	55.00
56.00	05600	RADIOISOTOPE	43,077	943,958	987,035	56.00
57.00	05700	CT SCAN	374,410	7,790,427	8,164,837	57.00
58.00	05800	MRI	114,616	2,921,229	3,035,845	58.00
60.00	06000	LABORATORY	904,187	11,983,127	12,887,314	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	55,646	103,028	158,674	63.00
65.00	06500	RESPIRATORY THERAPY	1,038,866	425,196	1,464,062	65.00
66.00	06600	PHYSICAL THERAPY	759,635	2,347,089	3,106,724	66.00
69.00	06900	ELECTROCARDIOLOGY	77,866	829,653	907,519	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,715	30,054	32,769	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	983,164	307,142	1,290,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077,646	2,225,816	3,303,462	73.00
76.00	03140	CARDIOLOGY	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	384,893	384,893	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC-PRINCETON	0	1,421,762	1,421,762	88.00
90.00	09000	CLINIC	345,049	500,929	845,978	90.00
90.01	04950	SLEEP LAB	0	495,899	495,899	90.01
90.02	09001	RHC-PRINCETON	0	538,875	538,875	90.02
91.00	09100	EMERGENCY	438,072	6,443,719	6,881,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,450	517,938	536,388	92.00
OTHER REIMBURSABLE COST CENTERS						
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	106.00
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	13,349,294	57,534,833	70,884,127	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	13,349,294	57,534,833	70,884,127	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Prepared: 9/22/2016 8:10 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600 RADIOISOTOPE	0.000000	56.00
57.00	05700 CT SCAN	0.000000	57.00
58.00	05800 MRI	0.000000	58.00
60.00	06000 LABORATORY	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03140 RADIOLOGY	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RHC-PRINCETON		88.00
90.00	09000 CLINIC	0.000000	90.00
90.01	04950 SLEEP LAB	0.000000	90.01
90.02	09001 RHC-PRINCETON	0.000000	90.02
91.00	09100 EMERGENCY	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS			
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	97.00
SPECIAL PURPOSE COST CENTERS			
106.00	10600 HEART ACQUISITION		106.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141337

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

Worksheet C
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

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	4,352,426		4,352,426	0	4,352,426	30.00
31.00	03100	INTENSIVE CARE UNIT	1,268,337		1,268,337	0	1,268,337	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,427,632		5,427,632	0	5,427,632	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	103,907		103,907	0	103,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,561,252		1,561,252	0	1,561,252	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	580,096		580,096	0	580,096	55.00
56.00	05600	RADIOISOTOPE	523,516		523,516	0	523,516	56.00
57.00	05700	CT SCAN	854,608		854,608	0	854,608	57.00
58.00	05800	MRI	759,942		759,942	0	759,942	58.00
60.00	06000	LABORATORY	3,046,360		3,046,360	0	3,046,360	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	92,043		92,043	0	92,043	63.00
65.00	06500	RESPIRATORY THERAPY	807,326	0	807,326	0	807,326	65.00
66.00	06600	PHYSICAL THERAPY	1,184,697	0	1,184,697	0	1,184,697	66.00
69.00	06900	ELECTROCARDIOLOGY	151,106		151,106	0	151,106	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,450		14,450	0	14,450	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	924,427		924,427	0	924,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870,982		1,870,982	0	1,870,982	73.00
76.00	03140	CARDIOLOGY	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	191,607		191,607	0	191,607	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC-PRINCETON	1,703,925		1,703,925	0	1,703,925	88.00
90.00	09000	CLINIC	541,210		541,210	0	541,210	90.00
90.01	04950	SLEEP LAB	144,345		144,345	0	144,345	90.01
90.02	09001	RHC-PRINCETON	851,225		851,225	0	851,225	90.02
91.00	09100	EMERGENCY	3,050,421		3,050,421	0	3,050,421	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	525,149		525,149	0	525,149	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
SPECIAL PURPOSE COST CENTERS								
106.00	10600	HEART ACQUISITION	0		0	0	0	106.00
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,530,989	0	30,530,989	0	30,530,989	200.00
201.00		Less Observation Beds	525,149		525,149		525,149	201.00
202.00		Total (see instructions)	30,005,840	0	30,005,840	0	30,005,840	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Prepared: 9/22/2016 8:10 pm
		Title XIX	Hospital	Cost

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	3,084,050		3,084,050	30.00
31.00	03100	INTENSIVE CARE UNIT	790,365		790,365	31.00
43.00	04300	NURSERY	0		0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,525,007	10,771,506	13,296,513	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	311,039	440,342	751,381	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,928	3,761,433	3,973,361	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	193,506	2,350,818	2,544,324	55.00
56.00	05600	RADIOISOTOPE	43,077	943,958	987,035	56.00
57.00	05700	CT SCAN	374,410	7,790,427	8,164,837	57.00
58.00	05800	MRI	114,616	2,921,229	3,035,845	58.00
60.00	06000	LABORATORY	904,187	11,983,127	12,887,314	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	55,646	103,028	158,674	63.00
65.00	06500	RESPIRATORY THERAPY	1,038,866	425,196	1,464,062	65.00
66.00	06600	PHYSICAL THERAPY	759,635	2,347,089	3,106,724	66.00
69.00	06900	ELECTROCARDIOLOGY	77,866	829,653	907,519	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,715	30,054	32,769	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	983,164	307,142	1,290,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,077,646	2,225,816	3,303,462	73.00
76.00	03140	CARDIOLOGY	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	384,893	384,893	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RHC-PRINCETON	0	1,421,762	1,421,762	88.00
90.00	09000	CLINIC	345,049	500,929	845,978	90.00
90.01	04950	SLEEP LAB	0	495,899	495,899	90.01
90.02	09001	RHC-PRINCETON	0	538,875	538,875	90.02
91.00	09100	EMERGENCY	438,072	6,443,719	6,881,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	18,450	517,938	536,388	92.00
OTHER REIMBURSABLE COST CENTERS						
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS						
106.00	10600	HEART ACQUISITION	0	0	0	106.00
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	13,349,294	57,534,833	70,884,127	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	13,349,294	57,534,833	70,884,127	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet C Part I Date/Time Prepared: 9/22/2016 8:10 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03140 RADIOLOGY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC-PRINCETON	0.000000		88.00
90.00	09000 CLINIC	0.000000		90.00
90.01	04950 SLEEP LAB	0.000000		90.01
90.02	09001 RHC-PRINCETON	0.000000		90.02
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
SPECIAL PURPOSE COST CENTERS				
106.00	10600 HEART ACQUISITION			106.00
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 ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part II Date/Time Prepared: 9/22/2016 8:10 pm
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	469,844	13,296,513	0.035336	1,317,439	46,553	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	18,557	751,381	0.024697	86,944	2,147	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	101,464	3,973,361	0.025536	125,757	3,211	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	25,926	2,544,324	0.010190	112,395	1,145	55.00
56.00	05600 RADIOISOTOPE	14,132	987,035	0.014318	30,598	438	56.00
57.00	05700 CT SCAN	129,636	8,164,837	0.015877	209,989	3,334	57.00
58.00	05800 MRI	294,402	3,035,845	0.096975	63,435	6,152	58.00
60.00	06000 LABORATORY	136,202	12,887,314	0.010569	503,545	5,322	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,138	158,674	0.007172	37,606	270	63.00
65.00	06500 RESPIRATORY THERAPY	36,308	1,464,062	0.024799	642,399	15,931	65.00
66.00	06600 PHYSICAL THERAPY	60,028	3,106,724	0.019322	268,359	5,185	66.00
69.00	06900 ELECTROCARDIOLOGY	28,808	907,519	0.031744	31,793	1,009	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,369	32,769	0.102811	1,801	185	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,816	1,290,306	0.014583	517,857	7,552	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	42,351	3,303,462	0.012820	551,167	7,066	73.00
76.00	03140 RADIOLOGY	0	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	20,263	384,893	0.052646	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC-PRINCETON	58,920	1,421,762	0.041442	0	0	88.00
90.00	09000 CLINIC	37,813	845,978	0.044697	7,974	356	90.00
90.01	04950 SLEEP LAB	13,640	495,899	0.027506	0	0	90.01
90.02	09001 RHC-PRINCETON	42,889	538,875	0.079590	0	0	90.02
91.00	09100 EMERGENCY	137,921	6,881,791	0.020041	5,623	113	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	36,609	536,388	0.068251	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00	Total (lines 50-199)	1,729,036	67,009,712		4,514,681	105,969	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141337

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

Worksheet D
Part IV
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RHC-PRINCETON	0	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	04950	SLEEP LAB	0	0	0	0	0	0	90.01
90.02	09001	RHC- PRINCETON	0	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141337

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

Worksheet D
Part IV
Date/Time Prepared:
9/22/2016 8:10 pm

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	13,296,513	0.000000	0.000000	1,317,439	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	751,381	0.000000	0.000000	86,944	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,973,361	0.000000	0.000000	125,757	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,544,324	0.000000	0.000000	112,395	55.00
56.00	05600	RADIOISOTOPE	0	987,035	0.000000	0.000000	30,598	56.00
57.00	05700	CT SCAN	0	8,164,837	0.000000	0.000000	209,989	57.00
58.00	05800	MRI	0	3,035,845	0.000000	0.000000	63,435	58.00
60.00	06000	LABORATORY	0	12,887,314	0.000000	0.000000	503,545	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	158,674	0.000000	0.000000	37,606	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,464,062	0.000000	0.000000	642,399	65.00
66.00	06600	PHYSICAL THERAPY	0	3,106,724	0.000000	0.000000	268,359	66.00
69.00	06900	ELECTROCARDIOLOGY	0	907,519	0.000000	0.000000	31,793	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	32,769	0.000000	0.000000	1,801	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,290,306	0.000000	0.000000	517,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,303,462	0.000000	0.000000	551,167	73.00
76.00	03140	CARDIOLOGY	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	384,893	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RHC-PRINCETON	0	1,421,762	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	845,978	0.000000	0.000000	7,974	90.00
90.01	04950	SLEEP LAB	0	495,899	0.000000	0.000000	0	90.01
90.02	09001	RHC-PRINCETON	0	538,875	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	6,881,791	0.000000	0.000000	5,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	536,388	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	67,009,712			4,514,681	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part IV Date/Time Prepared: 9/22/2016 8:10 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03140 CARDIOLOGY	0	0	0		76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RHC-PRINCETON	0	0	0		88.00
90.00	09000 CLINIC	0	0	0		90.00
90.01	04950 SLEEP LAB	0	0	0		90.01
90.02	09001 RHC-PRINCETON	0	0	0		90.02
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part V Date/Time Prepared: 9/22/2016 8:10 pm
		Title XVIII	Hospital	Cost

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	0.408200	0	4,615,396	923	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.138288	0	224,378	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.392930	0	1,340,633	1,013	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.227996	0	1,121,535	0	0	55.00
56.00	05600 RADIOISOTOPE	0.530393	0	447,409	127	0	56.00
57.00	05700 CT SCAN	0.104669	0	3,315,340	11,213	0	57.00
58.00	05800 MRI	0.250323	0	1,026,805	0	0	58.00
60.00	06000 LABORATORY	0.236384	0	5,163,387	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.580076	0	49,653	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.551429	0	205,515	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.381333	0	864,791	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.166505	0	425,079	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.440966	0	7,285	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.716440	0	85,886	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.566370	0	1,090,690	38,785	0	73.00
76.00	03140 RADIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.497819	0	235,581	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RHC-PRINCETON	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.639745	0	280,438	3,647	0	90.00
90.01	04950 SLEEP LAB	0.291077	0	157,129	0	0	90.01
90.02	09001 RHC-PRINCETON	1.579633	0	214,179	542	0	90.02
91.00	09100 EMERGENCY	0.443260	0	2,432,448	13,592	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.979047	0	269,639	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00	Subtotal (see instructions)		0	23,573,196	69,842	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	23,573,196	69,842	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet D Part V Date/Time Prepared: 9/22/2016 8:10 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	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	1,884,005	377	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	31,029	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	526,775	398	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	255,705	0	55.00
56.00	05600 RADIOISOTOPE	237,303	67	56.00
57.00	05700 CT SCAN	347,013	1,174	57.00
58.00	05800 MRI	257,033	0	58.00
60.00	06000 LABORATORY	1,220,542	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	28,803	0	63.00
65.00	06500 RESPIRATORY THERAPY	113,327	0	65.00
66.00	06600 PHYSICAL THERAPY	329,773	0	66.00
69.00	06900 ELECTROCARDIOLOGY	70,778	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,212	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	61,532	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	617,734	21,967	73.00
76.00	03140 CARDIOLOGY	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	117,277	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RHC-PRINCETON	0	0	88.00
90.00	09000 CLINIC	179,409	2,333	90.00
90.01	04950 SLEEP LAB	45,737	0	90.01
90.02	09001 RHC-PRINCETON	338,324	856	90.02
91.00	09100 EMERGENCY	1,078,207	6,025	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	263,989	0	92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00	Subtotal (see instructions)	8,007,507	33,197	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	8,007,507	33,197	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141337

Period: From 05/01/2015

Worksheet D

Component CCN: 14Z337

To 04/30/2016

Part V
Date/Time Prepared:
9/22/2016 8:10 pm

Title XVIII

Swing Beds - SNF

Cost

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	0.408200	0	0	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.138288	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.392930	0	0	0	0 54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.227996	0	0	0	0 55.00
56.00 05600 RADIOISOTOPE	0.530393	0	0	0	0 56.00
57.00 05700 CT SCAN	0.104669	0	0	0	0 57.00
58.00 05800 MRI	0.250323	0	0	0	0 58.00
60.00 06000 LABORATORY	0.236384	0	0	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.580076	0	0	0	0 63.00
65.00 06500 RESPIRATORY THERAPY	0.551429	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.381333	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY	0.166505	0	0	0	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.440966	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.716440	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.566370	0	0	0	0 73.00
76.00 03140 RADIOLOGY	0.000000	0	0	0	0 76.00
76.97 07697 CARDIAC REHABILITATION	0.497819	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RHC-PRINCETON	0.000000				0 88.00
90.00 09000 CLINIC	0.639745	0	0	0	0 90.00
90.01 04950 SLEEP LAB	0.291077	0	0	0	0 90.01
90.02 09001 RHC-PRINCETON	1.579633	0	0	0	0 90.02
91.00 09100 EMERGENCY	0.443260	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.979047	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0 97.00
200.00 Subtotal (see instructions)		0	0	0	0 200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141337

Period: From 05/01/2015

Worksheet D

Component CCN: 14Z337

To 04/30/2016

Part V
Date/Time Prepared:
9/22/2016 8:10 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03140 RADIOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RHC-PRINCETON	0	0		88.00
90.00 09000 CLINIC	0	0		90.00
90.01 04950 SLEEP LAB	0	0		90.01
90.02 09001 RHC-PRINCETON	0	0		90.02
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Prepared: 9/22/2016 8:10 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,757	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,222	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)		1,892	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		341	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)		170	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		16	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)		8	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,170	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)		305	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)		153	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,352,426	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)		2,153	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)		1,076	25.00
26.00	Total swing-bed cost (see instructions)		816,414	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,536,012	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,536,012	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)		1,591.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,861,891	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,861,891	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet D-1 Date/Time Prepared: 9/22/2016 8:10 pm	
Title XVIII			Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,268,337	271	4,680.21	155	725,433	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,973,202	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,560,526	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)						0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 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)					485,365	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					243,478	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					728,843	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)					330	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,591.36	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					525,149	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141337		Period: From 05/01/2015 To 04/30/2016		Worksheet D-1 Date/Time Prepared: 9/22/2016 8:10 pm	
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	303,417	4,352,426	0.069712	525,149	36,609	90.00
91.00	Nursing School cost	0	4,352,426	0.000000	525,149	0	91.00
92.00	Allied health cost	0	4,352,426	0.000000	525,149	0	92.00
93.00	All other Medical Education	0	4,352,426	0.000000	525,149	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet D-3 Date/Time Prepared: 9/22/2016 8:10 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,497,941	30.00
31.00	03100	INTENSIVE CARE UNIT		414,857	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.408200	1,317,439	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.138288	86,944	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.392930	125,757	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.227996	112,395	55.00
56.00	05600	RADIOISOTOPE	0.530393	30,598	56.00
57.00	05700	CT SCAN	0.104669	209,989	57.00
58.00	05800	MRI	0.250323	63,435	58.00
60.00	06000	LABORATORY	0.236384	503,545	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.580076	37,606	63.00
65.00	06500	RESPIRATORY THERAPY	0.551429	642,399	65.00
66.00	06600	PHYSICAL THERAPY	0.381333	268,359	66.00
69.00	06900	ELECTROCARDIOLOGY	0.166505	31,793	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.440966	1,801	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.716440	517,857	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.566370	551,167	73.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.497819	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC-PRINCETON	0.000000	0	88.00
90.00	09000	CLINIC	0.639745	7,974	90.00
90.01	04950	SLEEP LAB	0.291077	0	90.01
90.02	09001	RHC- PRINCETON	1.579633	0	90.02
91.00	09100	EMERGENCY	0.443260	5,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.979047	0	92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		4,514,681	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		4,514,681	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet D-3	
		Component CCN: 14Z337		Date/Time Prepared: 9/22/2016 8:10 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.408200	1	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.138288	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.392930	9,576	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.227996	6,792	55.00
56.00	05600	RADIOISOTOPE	0.530393	0	56.00
57.00	05700	CT SCAN	0.104669	0	57.00
58.00	05800	MRI	0.250323	0	58.00
60.00	06000	LABORATORY	0.236384	40,657	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.580076	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.551429	120,649	65.00
66.00	06600	PHYSICAL THERAPY	0.381333	307,019	66.00
69.00	06900	ELECTROCARDIOLOGY	0.166505	1,692	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.440966	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.716440	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.566370	78,499	73.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.497819	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RHC-PRINCETON	0.000000		88.00
90.00	09000	CLINIC	0.639745	0	90.00
90.01	04950	SLEEP LAB	0.291077	0	90.01
90.02	09001	RHC- PRINCETON	1.579633	0	90.02
91.00	09100	EMERGENCY	0.443260	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.979047	0	92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		564,885	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		564,885	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prepared: 9/22/2016 8:10 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			8,040,704 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			8,040,704 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 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)			0 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)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			8,121,111 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)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			55,756 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,638,544 26.00
27.00	Subtotal [(Lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			4,426,811 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			4,426,811 30.00
31.00	Primary payer payments			4,360 31.00
32.00	Subtotal (line 30 minus line 31)			4,422,451 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)			292,974 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			190,433 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			251,037 36.00
37.00	Subtotal (see instructions)			4,612,884 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			4,612,884 40.00
40.01	Sequestration adjustment (see instructions)			92,258 40.01
41.00	Interim payments			5,029,836 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-509,210 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: 141337

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

Worksheet E-1
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

		Title XVIII		Hospital		Cost	
		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		3,551,631		5,357,090	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	11/24/2015	147,366		0		3.01
3.02		04/21/2016	394,761		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	11/24/2015	102,586		3.50
3.51			0	04/21/2016	224,668		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)		542,127		-327,254		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)		4,093,758		5,029,836		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		43,758		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		509,210		6.02
7.00	Total Medicare program liability (see instructions)		4,137,516		4,520,626		7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141337
Component CCN: 14Z337

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

Worksheet E-1
Part I
Date/Time Prepared:
9/22/2016 8:10 pm

Title XVIII Swing Beds - SNF Cost

		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		968,008		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	11/24/2015	39,127		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	04/21/2016	19,036		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)		20,091		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)		988,099		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		39,167		0	6.02
7.00	Total Medicare program liability (see instructions)		948,932		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: 141337

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

Worksheet E-1
Part II
Date/Time Prepared:
9/22/2016 8:10 pm

		Title XVIII	Hospital	Cost
				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			740 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1,325 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			169 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			2,163 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			70,884,127 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			385,091 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: 141337	Period:	Worksheet E-2
		Component CCN: 14Z337	From 05/01/2015 To 04/30/2016	Date/Time Prepared: 9/22/2016 8:10 pm
		Title XVIII	Swing Beds - SNF	Cost
			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)		736,131	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
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)		245,702	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		458	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		981,833	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		981,833	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		981,833	0
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		13,535	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		968,298	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
16.55	410A RURAL DEMONSTRATION PROJECT		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		968,298	0
19.01	Sequestration adjustment (see instructions)		19,366	0
20.00	Interim payments		988,099	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		-39,167	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet E-3 Part V Date/Time Prepared: 9/22/2016 8:10 pm
		Title XVII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			4,560,526 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			4,560,526 4.00
5.00	Primary payer payments			3,740 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4,602,391 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	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 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			4,602,391 19.00
20.00	Deductibles (exclude professional component)			395,892 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			4,206,499 22.00
23.00	Coinurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			4,206,499 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			23,779 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			15,456 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			15,129 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4,221,955 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			4,221,955 30.00
30.01	Sequestration adjustment (see instructions)			84,439 30.01
31.00	Interim payments			4,093,758 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			43,758 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

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

Provider CCN: 141337

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

Worksheet G

Date/Time Prepared:
9/22/2016 8:10 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,505,612	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	5,602,153	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	380,412	0	0	0	7.00
8.00	Prepaid expenses	356,826	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,845,003	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,058,874	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	15,425,428	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,484,302	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,897,493	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	2,567,823	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,465,316	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,794,621	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,021,508	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,965,414	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	511,230	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	1,029,368	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,527,520	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,014,555	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,197,140	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,211,695	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,739,215	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	27,055,406				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)	27,055,406	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,794,621	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141337

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

Worksheet G-1

Date/Time Prepared:
9/22/2016 8:10 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		26,655,809		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		399,597		0		2.00
3.00	Total (sum of line 1 and line 2)		27,055,406		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,055,406		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		27,055,406		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			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: 141337

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/22/2016 8:10 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,350,214		3,350,214	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)	3,350,214		3,350,214	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	752,865		752,865	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)	752,865		752,865	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,103,079		4,103,079	17.00
18.00	Ancillary services	8,664,482	49,126,463	57,790,945	18.00
19.00	Outpatient services	794,041	15,035,500	15,829,541	19.00
20.00	RHC-PRINCETON	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	0	0	0	27.00
27.01	PHARMACY	0	191	191	27.01
27.02	DIETARY	0	2,116	2,116	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,561,602	64,164,270	77,725,872	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,077,371		29.00
30.00		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		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		39,077,371		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141337

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

Worksheet G-3

Date/Time Prepared:
9/22/2016 8:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,725,872	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,335,682	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,390,190	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	39,077,371	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-687,181	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	148,832	6.00
7.00	Income from investments	56,782	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OP	882,403	24.00
24.01	OTHER NON-OP	0	24.01
25.00	Total other income (sum of lines 6-24)	1,088,017	25.00
26.00	Total (line 5 plus line 25)	400,836	26.00
27.00	OTHER NON-OP	1,239	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	1,239	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	399,597	29.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141337 Component CCN: 148549	Period: From 05/01/2015 To 04/30/2016	Worksheet M-1 Date/Time Prepared: 9/22/2016 8:10 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	333,764	0	333,764	79,408	413,172	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	222,852	0	222,852	0	222,852	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	345,099	0	345,099	0	345,099	9.00
10.00	Subtotal (sum of lines 1 through 9)	901,715	0	901,715	79,408	981,123	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	901,715	0	901,715	79,408	981,123	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	2,715	2,715	0	2,715	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,715	2,715	0	2,715	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	146,036	146,036	0	146,036	29.00
30.00	Administrative Costs	0	4,829	4,829	0	4,829	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	150,865	150,865	0	150,865	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	901,715	153,580	1,055,295	79,408	1,134,703	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 141337

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

Worksheet M-1

Component CCN: 148549

Date/Time Prepared:
9/22/2016 8:10 pm

Rural Health
Clinic (RHC) I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	413,172	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	222,852	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	345,099	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	981,123	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	981,123	22.00
COSTS OTHER THAN RHC/FOHC SERVICES				
23.00	Pharmacy	0	2,715	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,715	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	146,036	29.00
30.00	Administrative Costs	0	4,829	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	150,865	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,134,703	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141337 Component CCN: 148549	Period: From 05/01/2015 To 04/30/2016	Worksheet M-2 Date/Time Prepared: 9/22/2016 8:10 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.04	4,081	4,200	4,368	1.00
2.00	Physician Assistant	0.00	0	0	0	2.00
3.00	Nurse Practitioner	1.08	3,404	2,100	2,268	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.12	7,485		6,636	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FOHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FOHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.12	7,485			8.00
9.00	Physician Services Under Agreements		0			9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		981,123 10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		2,715 11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		983,838 12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		0.997240 13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)		150,865 14.00
15.00	Parent provider overhead allocated to facility (see instructions)		569,222 15.00
16.00	Total overhead (sum of lines 14 and 15)		720,087 16.00
17.00	Allowable GME overhead (see instructions)		0 17.00
18.00	Subtotal (see instructions)		720,087 18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		718,100 19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		1,699,223 20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet M-3
		Component CCN: 148549		Date/Time Prepared: 9/22/2016 8:10 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,699,223	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		87,904	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,611,319	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,485	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		7,485	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		215.27	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)	215.27	215.27	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,248	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	483,927	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		483,927	16.00
16.01	Total program charges (see instructions)(from contractor's records)		318,424	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		49,604	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		75,386	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		311,592	16.04
16.05	Total program cost (see instructions)		386,978	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,051	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		49,777	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		386,978	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		14,922	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		401,900	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		401,900	26.00
26.01	Sequestration adjustment (see instructions)		8,038	26.01
27.00	Interim payments		322,657	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		71,205	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141337 Component CCN: 148549	Period: From 05/01/2015 To 04/30/2016	Worksheet M-4 Date/Time Prepared: 9/22/2016 8:10 pm		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
				Pneumococcal	Influenza	
				1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)			981,123	981,123	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			0.004158	0.003438	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			4,080	3,373	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			39,249	3,994	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			43,329	7,367	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)			981,123	981,123	6.00
7.00	Total overhead (from Wkst. M-2, line 16)			720,087	720,087	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			0.044163	0.007509	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			31,801	5,407	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			75,130	12,774	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)			283	234	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)			265.48	54.59	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries			34	108	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)			9,026	5,896	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)				87,904	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)				14,922	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141337	Period: From 05/01/2015 To 04/30/2016	Worksheet M-5
	Component CCN: 148549		Date/Time Prepared: 9/22/2016 8:10 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		322,657	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	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	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		322,657	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	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		71,205	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		393,862	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00