

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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S Parts I-III Date/Time Prepared: 9/27/2017 4:55 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 9/27/2017	Time: 4:55 pm
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for Full or "L" for Low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CGH MEDICAL CENTER (14-0043) for the cost reporting period beginning 05/01/2016 and ending 04/30/2017 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	-175,963	-101,580	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-218		0	9.00
200.00 Total	0	-175,963	-101,798	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: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet S-2 Part I Date/Time Prepared: 9/26/2017 11:01 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 100 EAST LEFEVRE ROAD	PO Box:							1.00		
2.00	City: STERLING	State: IL		Zip Code: 61081-1279		County: WHITESIDE			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	6.00	7.00	8.00		
							V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	CGH MEDICAL CENTER		140043	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF	CGH MEDICAL CENTER		14U043	99914		01/13/2004	N	P	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA	CGH HOME NURSING		147562	99914		05/05/1994	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - 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)						05/01/2016	04/30/2017		20.00	
21.00	Type of Control (see instructions)						12			21.00	
<u>Inpatient PPS Information</u>											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							1		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,178	673	0		1	12	108	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0			25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/26/2017 11:01 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	05/01/2016	04/30/2017			38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))		
		1.00	2.00	3.00		
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)			N	N 0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N 0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
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.				N	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)?	N				105.00			
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00			
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00			
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00			
		Physical		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	
								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			
								1.00	
								2.00	
								3.00	
Miscellaneous Cost Reporting Information									
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y						116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N						117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1						118.00	
		Premiums		Losses		Insurance			
		1.00		2.00		3.00			
118.01	List amounts of malpractice premiums and paid losses:	702,289		0		0		118.01	
								1.00	
								2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N						118.02	
119.00	DO NOT USE THIS LINE							119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N				120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N						121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N						122.00	
Transplant Center Information									
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N						125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/26/2017 11:01 am			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
	1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:	Contractor's Number:			141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:	Zip Code:			143.00	
					1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00	
					1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
					1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
					1.00		
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.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
168.01	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: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part I Date/Time Prepared: 9/26/2017 11:01 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet S-2 Part II Date/Time Prepared: 9/26/2017 11:01 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	07/20/2017	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	
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	07/28/2017	Y	07/28/2017
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: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part II Date/Time Prepared: 9/26/2017 11:01 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		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			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN		WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSENALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446		KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S-2 Part II Date/Time Prepared: 9/26/2017 11:01 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR		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: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2017 11:01 am

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	
					Ti tle V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	89	32,485	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		89	32,485	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		97	35,405	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		97				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2017 11:01 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,626	1,470	11,777			1.00
2.00 HMO and other (see instructions)	922	686				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,626	1,470	11,777			7.00
8.00 INTENSIVE CARE UNIT	880	135	1,391			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		573	1,009			13.00
14.00 Total (see instructions)	7,506	2,178	14,177	0.00	1,274.93	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	2,477	0	6,359	0.00	15.43	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	1,290.36	27.00
28.00 Observation Bed Days		0	3,392			28.00
29.00 Ambulance Trips	2,223					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	108	166			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: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2017 11:01 am

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	2,025	664	4,068	1.00
2.00 HMO and other (see instructions)			241	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,025	664	4,068	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
9/26/2017 11:01 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	91,091,446	0	91,091,446	2,683,283.20	33.95	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		2,086,606	0	2,086,606	14,456.00	144.34	3.00
4.00	Physician-Part A - Administrative		171,500	0	171,500	1,143.00	150.04	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		27,254,935	0	27,254,935	167,966.04	162.26	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,569,234	0	7,569,234	245,065.60	30.89	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		434,125	0	434,125	8,619.75	50.36	11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		22,787,950	0	22,787,950			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,704,218	0	2,704,218			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		369,001	0	369,001			21.00
22.00	Physician Part A - Administrative		29,895	0	29,895			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		4,618,917	0	4,618,917			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related organization wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
9/26/2017 11:01 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	510,029	0	510,029	14,955.20	26.00
27.00	Administrative & General	5.00	11,553,612	44,356	11,597,968	418,620.80	27.00
28.00	Administrative & General under contract (see inst.)		147,417	0	147,417	825.80	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	1,181,740	0	1,181,740	47,964.80	30.00
31.00	Laundry & Linen Service	8.00	252,268	0	252,268	21,507.20	31.00
32.00	Housekeeping	9.00	1,021,180	0	1,021,180	77,584.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	904,437	-691,290	213,147	14,788.60	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	691,290	691,290	47,965.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	945,866	-266,044	679,822	16,806.20	38.00
39.00	Central Services and Supply	14.00	435,749	0	435,749	21,632.00	39.00
40.00	Pharmacy	15.00	1,158,411	-1,158,411	0	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	2,003,449	0	2,003,449	96,200.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet S-3
Part III
Date/Time Prepared:
9/26/2017 11:01 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	61,897,322	0	61,897,322	2,501,686.96	24.74	1.00
2.00	Excluded area salaries (see instructions)	7,569,234	0	7,569,234	245,065.60	30.89	2.00
3.00	Subtotal salaries (line 1 minus line 2)	54,328,088	0	54,328,088	2,256,621.36	24.07	3.00
4.00	Subtotal other wages & related costs (see inst.)	434,125	0	434,125	8,619.75	50.36	4.00
5.00	Subtotal wage-related costs (see inst.)	22,817,845	0	22,817,845	0.00	42.00	5.00
6.00	Total (sum of lines 3 thru 5)	77,580,058	0	77,580,058	2,265,241.11	34.25	6.00
7.00	Total overhead cost (see instructions)	20,114,158	-1,380,099	18,734,059	778,849.60	24.05	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 9/26/2017 11:01 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,263,543	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	4,923,896	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	15,975,360	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	152,215	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	399,994	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	35,538	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,127,896	17.00
18.00	Medicare Taxes - Employers Portion Only	1,273,301	18.00
19.00	Unemployment Insurance	13,941	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	344,297	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	30,509,981	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S-3 Part V Date/Time Prepared: 9/26/2017 11:01 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	459,529	30,509,981	1.00
2.00	Hospital	434,125	30,509,981	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	25,404	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0043 Component CCN: 14-7562		Period: From 05/01/2016 To 04/30/2017		Worksheet S-4 Date/Time Prepared: 9/26/2017 11:01 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WHITESIDE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	310	0	1,772	2,082	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	225.00	50.00	255.00	530.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		2.23	0.00	2.23	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			10.28	0.00	10.28	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.87	0.12	1.99	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.01	0.01	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.05	0.00	0.05	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.00	0.00	1.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,278	0	147	31	1,456	21.00
22.00	Skilled Nursing Visit Charges	354,681	0	37,245	6,630	398,556	22.00
23.00	Physical Therapy Visits	740	0	18	0	758	23.00
24.00	Physical Therapy Visit Charges	135,420	0	3,294	0	138,714	24.00
25.00	Occupational Therapy Visits	11	0	0	0	11	25.00
26.00	Occupational Therapy Visit Charges	1,925	0	0	0	1,925	26.00
27.00	Speech Pathology Visits	29	0	0	0	29	27.00
28.00	Speech Pathology Visit Charges	5,365	0	0	0	5,365	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	205	0	0	18	223	31.00
32.00	Home Health Aide Visit Charges	17,425	0	0	1,530	18,955	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,263	0	165	49	2,477	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	514,816	0	40,539	8,160	563,515	35.00
36.00	Total Number of Episodes (standard/non outlier)	210		56	6	272	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	6,577	0	3,117	637	10,331	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet S-10 Date/Time Prepared: 9/26/2017 11:01 am	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.237457	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			7,244,040	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			8,794,346	5.00
6.00	Medicaid charges			90,912,634	6.00
7.00	Medicaid cost (line 1 times line 6)			21,587,841	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)			5,549,455	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			84,560	9.00
10.00	Stand-alone CHIP charges			1,013,680	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			240,705	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			156,145	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, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			5,705,600	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	2,578,634	708,082	3,286,716	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	612,315	168,139	780,454	21.00
22.00	Partial payment by patients approved for charity care	183,296	0	183,296	22.00
23.00	Cost of charity care (line 21 minus line 22)	429,019	168,139	597,158	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)			11,014,750	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			876,498	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			10,138,252	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,407,399	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,004,557	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8,710,157	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet A Date/Time Prepared: 9/26/2017 11:01 am		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		11,874,493	11,874,493	-5,684,860	6,189,633	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	7,738,015	7,738,015	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	510,029	32,339,260	32,849,289	-1,095	32,848,194	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,553,612	17,464,336	29,017,948	535,000	29,552,948	5.00
7.00	00700	OPERATION OF PLANT	1,181,740	2,679,123	3,860,863	-11,098	3,849,765	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	252,268	147,145	399,413	0	399,413	8.00
9.00	00900	HOUSEKEEPING	1,021,180	1,177,612	2,198,792	-9,512	2,189,280	9.00
10.00	01000	DIETARY	904,437	913,824	1,818,261	-1,389,755	428,506	10.00
11.00	01100	CAFETERIA	0	0	0	1,389,755	1,389,755	11.00
13.00	01300	NURSING ADMINISTRATION	945,866	146,135	1,092,001	-270,909	821,092	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	435,749	322,756	758,505	-222,564	535,941	14.00
15.00	01500	PHARMACY	1,158,411	7,790,043	8,948,454	-8,524,991	423,463	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,003,449	800,901	2,804,350	0	2,804,350	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,341,485	1,133,042	11,474,527	-840,432	10,634,095	30.00
31.00	03100	INTENSIVE CARE UNIT	2,098,501	407,741	2,506,242	-761,709	1,744,533	31.00
43.00	04300	NURSERY	0	0	0	468,090	468,090	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,624,527	6,003,727	7,628,254	-5,653,317	1,974,937	50.00
51.00	05100	RECOVERY ROOM	816,944	255,280	1,072,224	-228,421	843,803	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	856,443	856,443	52.00
53.00	05300	ANESTHESIOLOGY	2,086,606	578,149	2,664,755	-427,000	2,237,755	53.00
53.01	05301	PAIN MANAGEMENT	945,282	97,085	1,042,367	-54,468	987,899	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,163,473	1,926,482	3,089,955	250,926	3,340,881	54.00
54.01	05401	ULTRASOUND	414,132	696,655	1,110,787	64,171	1,174,958	54.01
56.00	05600	RADIOISOTOPE	257,341	1,102,945	1,360,286	-907,949	452,337	56.00
57.00	05700	CT SCAN	528,370	1,832,261	2,360,631	-41,516	2,319,115	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	339,644	791,484	1,131,128	5,979	1,137,107	58.00
59.00	05900	CARDIAC CATHETERIZATION	632,432	1,984,986	2,617,418	-1,616,892	1,000,526	59.00
60.00	06000	LABORATORY	2,824,182	3,809,558	6,633,740	-1,521,133	5,112,607	60.00
65.00	06500	RESPIRATORY THERAPY	912,038	236,006	1,148,044	-161,863	986,181	65.00
66.00	06600	PHYSICAL THERAPY	321,641	13,676	335,317	-2,635	332,682	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,497	3,879	77,376	-2,091	75,285	67.00
68.00	06800	SPEECH PATHOLOGY	137,649	11,198	148,847	-2,283	146,564	68.00
69.00	06900	ELECTROCARDIOLOGY	763,991	181,777	945,768	-72,095	873,673	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	249,727	76,330	326,057	-24,495	301,562	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	13,670,089	13,670,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,371,032	19,371,032	73.00
74.00	07400	RENAL DIALYSIS	0	132,644	132,644	-713	131,931	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	975,064	855,673	1,830,737	-684,136	1,146,601	75.01
76.00	03950	DIABETIC EDUCATION	163,703	111,480	275,183	-3,349	271,834	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	432,502	770,139	1,202,641	-282,968	919,673	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	32,031,590	13,669,061	45,700,651	-12,283,582	33,417,069	90.00
91.00	09100	EMERGENCY	3,421,150	5,382,857	8,804,007	-471,768	8,332,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,542,756	316,818	1,859,574	-144,048	1,715,526	95.00
98.00	09850	HOME INFUSION	66,967	124,515	191,482	-16,388	175,094	98.00
101.00	10100	HOME HEALTH AGENCY	1,009,086	158,201	1,167,287	-38,491	1,128,796	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		605,756	605,756	-605,756	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	86,141,021	118,925,033	205,066,054	1,385,218	206,451,272	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,213	36,845	59,058	0	59,058	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,538,815	971,780	4,510,595	-14,513	4,496,082	192.00
194.00	07950	COMMUNITY SERVICE	287,112	109,427	396,539	-3,966	392,573	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	1,102,285	69,294	1,171,579	0	1,171,579	194.01
194.02	07952	OFFSITE BUILDINGS	0	1,507,930	1,507,930	-1,366,739	141,191	194.02
200.00		TOTAL (SUM OF LINES 118-199)	91,091,446	121,620,309	212,711,755	0	212,711,755	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A
Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-605,756	5,583,877	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-27,509	7,710,506	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,893,354	28,954,840	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,807,989	20,744,959	5.00
7.00	00700	OPERATION OF PLANT	-2,866	3,846,899	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	399,413	8.00
9.00	00900	HOUSEKEEPING	-394	2,188,886	9.00
10.00	01000	DIETARY	-6,467	422,039	10.00
11.00	01100	CAFETERIA	-798,662	591,093	11.00
13.00	01300	NURSING ADMINISTRATION	0	821,092	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	535,941	14.00
15.00	01500	PHARMACY	-37,663	385,800	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-96,963	2,707,387	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,832,250	7,801,845	30.00
31.00	03100	INTENSIVE CARE UNIT	-36,498	1,708,035	31.00
43.00	04300	NURSERY	0	468,090	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,974,937	50.00
51.00	05100	RECOVERY ROOM	0	843,803	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	856,443	52.00
53.00	05300	ANESTHESIOLOGY	-2,188,591	49,164	53.00
53.01	05301	PAIN MANAGEMENT	-746,541	241,358	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,257,160	2,083,721	54.00
54.01	05401	ULTRASOUND	-496,785	678,173	54.01
56.00	05600	RADIOISOTOPE	-56,704	395,633	56.00
57.00	05700	CT SCAN	-1,593,915	725,200	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-584,427	552,680	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,000,526	59.00
60.00	06000	LABORATORY	-510,487	4,602,120	60.00
65.00	06500	RESPIRATORY THERAPY	-3,430	982,751	65.00
66.00	06600	PHYSICAL THERAPY	0	332,682	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	75,285	67.00
68.00	06800	SPEECH PATHOLOGY	0	146,564	68.00
69.00	06900	ELECTROCARDIOLOGY	-17,190	856,483	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-3,017	298,545	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,670,089	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,675,431	17,695,601	73.00
74.00	07400	RENAL DIALYSIS	0	131,931	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	GI LAB	0	1,146,601	75.01
76.00	03950	DIABETIC EDUCATION	0	271,834	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	-332,701	586,972	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-25,093,245	8,323,824	90.00
91.00	09100	EMERGENCY	-4,786,562	3,545,677	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-1,523	1,714,003	95.00
98.00	09850	HOME INFUSION	-1,055	174,039	98.00
101.00	10100	HOME HEALTH AGENCY	-1,107	1,127,689	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-56,496,242	149,955,030	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	59,058	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,496,082	192.00
194.00	07950	COMMUNITY SERVICE	0	392,573	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	0	1,171,579	194.01
194.02	07952	OFFSITE BUILDINGS	0	141,191	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-56,496,242	156,215,513	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - TO RECLASS INTEREST EXP & BOND EXP						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	605,756	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	204	2.00	
	0		0	605,960		
B - TO RECLASS L&D AND NURSERY COST						
1.00	NURSERY	43.00	439,734	19,291	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	804,561	35,297	2.00	
	0		1,244,295	54,588		
C - TO RECLASS OFFSITE BLDG						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169,738	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	741,813	2.00	
3.00	OTHER CAP REL COSTS	3.00	0	22,144	3.00	
4.00	OPERATION OF PLANT	7.00	0	447,193	4.00	
5.00	OFFSITE BUILDINGS	194.02	0	4,637	5.00	
6.00	OFFSITE BUILDINGS	194.02	0	9,512	6.00	
	0		0	1,395,037		
D - TO RECLASS PHYSICIAN REMUNERATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	15,675	0	1.00	
2.00		0.00	0	0	2.00	
	0		15,675	0		
E - TO RECLASS COLL AND BILLING EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	59,834	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	0		0	59,834		
F - TO RECLASS CAFETERIA EXPENSE						
1.00	CAFETERIA	11.00	691,290	698,465	1.00	
	0		691,290	698,465		
G - TO RECLASS DRUG EXPENSE						
1.00	DRUGS CHARGED TO PATIENTS	73.00	1,158,411	18,212,621	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
	0		1,158,411	18,212,621		
H - TO RECLASS MARKETING AND ADV						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,801	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
	0		0	16,801		
I - TO RECLASS TELEPHONE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	131,267	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-6

Date/Time Prepared:
9/26/2017 11:01 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
			0	131,267	
J - TO RECLASS PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	332,568	1.00
2.00	OTHER CAP REL COSTS	3.00	0	185,569	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
			0	518,137	
K - TO RECLASS MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,450	1.00
2.00		0.00	0	0	2.00
			0	17,450	
L - TO RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,670,089	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
			0	13,670,089	
M - TO RECLASS POPULATION HLTH MGMT					
1.00	ADMINISTRATIVE & GENERAL	5.00	601,164	303,151	1.00
			601,164	303,151	
N - TO RECLASS POST ICU					
1.00	ADULTS & PEDIATRICS	30.00	617,519	73,627	1.00
			617,519	73,627	
O - TO RECLASS MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,649,527	1.00
			0	7,649,527	
P - TO RECLASS UTILITIES EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	6,503	1.00
			0	6,503	
Q - TO RECLASS NURSING FLOATS					
1.00	ADULTS & PEDIATRICS	30.00	203,378	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	37,016	0	2.00
3.00	NURSERY	43.00	9,065	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	16,585	0	4.00
			266,044	0	
R - TO RECLASS RADIOLOGY MANAGEMENT					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	297,041	15,237	1.00
2.00	ULTRASOUND	54.01	73,669	3,779	2.00
3.00	RADIOISOTOPE	56.00	39,780	2,041	3.00
4.00	CT SCAN	57.00	104,644	5,368	4.00

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-6
Date/Time Prepared:
9/26/2017 11:01 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
5.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	57,349	2,942	5.00
			572,483	29,367	
S - TO RECLASS RADIOLOGY TECHS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	47,516	0	1.00
2.00	ULTRASOUND	54.01	11,025	0	2.00
			58,541	0	
500.00	Grand Total: Increases		5,225,422	43,442,424	500.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-6
Date/Time Prepared:
9/26/2017 11:01 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS INTEREST EXP & BOND EXP						
1.00	INTEREST EXPENSE	113.00	0	605,756	11	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	204	14	2.00
	0		0	605,960		
B - TO RECLASS L&D AND NURSERY COST						
1.00	ADULTS & PEDIATRICS	30.00	1,244,295	54,588	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,244,295	54,588		
C - TO RECLASS OFFSITE BLDG						
1.00	HOUSEKEEPING	9.00	0	9,512	13	1.00
2.00	OFFSITE BUILDINGS	194.02	0	1,380,888	10	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,637	9	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	0		0	1,395,037		
D - TO RECLASS PHYSICIAN REMUNERATION						
1.00	CLINIC	90.00	15,000	0	0	1.00
2.00	DIABETIC EDUCATION	76.00	675	0	0	2.00
	0		15,675	0		
E - TO RECLASS COLL AND BILLING EXP						
1.00	PHARMACY	15.00	0	7,529	0	1.00
2.00	AMBULANCE SERVICES	95.00	0	52,034	0	2.00
3.00	HOME INFUSION	98.00	0	114	0	3.00
4.00	HOME HEALTH AGENCY	101.00	0	157	0	4.00
	0		0	59,834		
F - TO RECLASS CAFETERIA EXPENSE						
1.00	DIETARY	10.00	691,290	698,465	0	1.00
	0		691,290	698,465		
G - TO RECLASS DRUG EXPENSE						
1.00	NURSING ADMINISTRATION	13.00	0	207	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	236	0	2.00
3.00	PHARMACY	15.00	1,158,411	7,263,169	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	6,694	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	1,144	0	5.00
6.00	RECOVERY ROOM	51.00	0	34,206	0	6.00
7.00	ANESTHESIOLOGY	53.00	0	228,135	0	7.00
8.00	PAIN MANAGEMENT	53.01	0	1,671	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,641	0	9.00
10.00	ULTRASOUND	54.01	0	26	0	10.00
11.00	RADIOISOTOPE	56.00	0	281,344	0	11.00
12.00	CT SCAN	57.00	0	78	0	12.00
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	54	0	14.00
15.00	LABORATORY	60.00	0	378	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,910	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	72	0	17.00
18.00	GI LAB	75.01	0	968	0	18.00
19.00	HYPERBARIC OXYGEN THERAPY	76.98	0	14,049	0	19.00
20.00	CLINIC	90.00	0	10,360,682	0	20.00
21.00	EMERGENCY	91.00	0	8,007	0	21.00
22.00	AMBULANCE SERVICES	95.00	0	7,945	0	22.00
	0		1,158,411	18,212,621		
H - TO RECLASS MARKETING AND ADV						
1.00	NURSING ADMINISTRATION	13.00	0	4,658	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,946	0	2.00
3.00	HYPERBARIC OXYGEN THERAPY	76.98	0	627	0	3.00
4.00	CLINIC	90.00	0	4,197	0	4.00
5.00	HOME HEALTH AGENCY	101.00	0	93	0	5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,280	0	6.00
	0		0	16,801		
I - TO RECLASS TELEPHONE EXPENSE						
1.00	OPERATION OF PLANT	7.00	0	1,555	0	1.00
2.00	PHARMACY	15.00	0	342	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	8,379	0	3.00
4.00	OPERATING ROOM	50.00	0	5,332	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	6,942	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	397	0	6.00
7.00	RADIOISOTOPE	56.00	0	43	0	7.00
8.00	LABORATORY	60.00	0	1,848	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	252	0	9.00
10.00	CLINIC	90.00	0	82,151	0	10.00
11.00	EMERGENCY	91.00	0	480	0	11.00

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-6
Date/Time Prepared:
9/26/2017 11:01 am

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
12.00	AMBULANCE SERVICES	95.00	0	9,124	0	12.00	
13.00	HOME HEALTH AGENCY	101.00	0	5,189	0	13.00	
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,233	0	14.00	
0			0	131,267			
J - TO RECLASS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,288	13	1.00	
2.00	OPERATION OF PLANT	7.00	0	332,568	0	2.00	
3.00	OPERATION OF PLANT	7.00	0	130,671	0	3.00	
4.00	AMBULANCE SERVICES	95.00	0	25,049	0	4.00	
5.00	HOME INFUSION	98.00	0	1,334	0	5.00	
6.00	HOME HEALTH AGENCY	101.00	0	16,261	0	6.00	
7.00	COMMUNITY SERVICE	194.00	0	3,966	0	7.00	
0			0	518,137			
K - TO RECLASS MALPRACTICE INSURANCE							
1.00	AMBULANCE SERVICES	95.00	0	17,200	0	1.00	
2.00	HOME INFUSION	98.00	0	250	0	2.00	
0			0	17,450			
L - TO RECLASS MEDICAL SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,095	0	1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	222,328	0	2.00	
3.00	PHARMACY	15.00	0	95,540	0	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	421,000	0	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	106,435	0	5.00	
6.00	OPERATING ROOM	50.00	0	5,647,985	0	6.00	
7.00	RECOVERY ROOM	51.00	0	194,215	0	7.00	
8.00	ANESTHESIOLOGY	53.00	0	191,923	0	8.00	
9.00	PAIN MANAGEMENT	53.01	0	52,797	0	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	104,884	0	10.00	
11.00	ULTRASOUND	54.01	0	24,276	0	11.00	
12.00	RADIOISOTOPE	56.00	0	668,383	0	12.00	
13.00	CT SCAN	57.00	0	151,450	0	13.00	
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	54,307	0	14.00	
15.00	CARDIAC CATHETERIZATION	59.00	0	1,616,838	0	15.00	
16.00	LABORATORY	60.00	0	1,518,907	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	159,953	0	17.00	
18.00	PHYSICAL THERAPY	66.00	0	2,635	0	18.00	
19.00	OCCUPATIONAL THERAPY	67.00	0	2,091	0	19.00	
20.00	SPEECH PATHOLOGY	68.00	0	2,283	0	20.00	
21.00	ELECTROCARDIOLOGY	69.00	0	71,771	0	21.00	
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	24,495	0	22.00	
23.00	RENAL DIALYSIS	74.00	0	713	0	23.00	
24.00	GI LAB	75.01	0	683,168	0	24.00	
25.00	DIABETIC EDUCATION	76.00	0	2,674	0	25.00	
26.00	HYPERBARIC OXYGEN THERAPY	76.98	0	268,292	0	26.00	
27.00	CLINIC	90.00	0	858,696	0	27.00	
28.00	EMERGENCY	91.00	0	463,281	0	28.00	
29.00	AMBULANCE SERVICES	95.00	0	26,193	0	29.00	
30.00	HOME INFUSION	98.00	0	14,690	0	30.00	
31.00	HOME HEALTH AGENCY	101.00	0	16,791	0	31.00	
0			0	13,670,089			
M - TO RECLASS POPULATION HLTH MGMT							
1.00	CLINIC	90.00	601,164	303,151	0	1.00	
0			601,164	303,151			
N - TO RECLASS POST ICU							
1.00	INTENSIVE CARE UNIT	31.00	617,519	73,627	0	1.00	
0			617,519	73,627			
O - TO RECLASS MME DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,649,527	9	1.00	
0			0	7,649,527			
P - TO RECLASS UTILITIES EXPENSE							
1.00	AMBULANCE SERVICES	95.00	0	6,503	0	1.00	
0			0	6,503			
Q - TO RECLASS NURSING FLOATS							
1.00	NURSING ADMINISTRATION	13.00	266,044	0	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	
0			266,044	0			
R - TO RECLASS RADIOLOGY MANAGEMENT							
1.00	ADMINISTRATIVE & GENERAL	5.00	572,483	29,367	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
4.00		0.00	0	0	0	4.00	

RECLASSIFICATIONS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-6

Date/Time Prepared:
9/26/2017 11:01 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
5.00		0.00	0	0	0	5.00
			572,483	29,367		
S - TO RECLASS RADIOLOGY TECHS						
1.00	CLINIC	90.00	58,541	0	0	1.00
2.00		0.00	0	0	0	2.00
			58,541	0		
500.00	Grand Total: Decreases		5,225,422	43,442,424		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-7
Part I
Date/Time Prepared:
9/26/2017 11:01 am

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,649,399	75,041	0	75,041	0	1.00
2.00	Land Improvements	4,104,653	62,036	0	62,036	5,850	2.00
3.00	Buildings and Fixtures	89,348,793	875,138	0	875,138	137,445	3.00
4.00	Building Improvements	13,733,621	0	0	0	104,449	4.00
5.00	Fixed Equipment	509,585	68,123	0	68,123	75,205	5.00
6.00	Movable Equipment	85,862,849	4,109,130	0	4,109,130	8,386,458	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	196,208,900	5,189,468	0	5,189,468	8,709,407	8.00
9.00	Reconciling Items	-553,746	-893,788	0	-893,788	0	9.00
10.00	Total (line 8 minus line 9)	196,762,646	6,083,256	0	6,083,256	8,709,407	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,724,440	0				1.00
2.00	Land Improvements	4,160,839	0				2.00
3.00	Buildings and Fixtures	90,086,486	0				3.00
4.00	Building Improvements	13,629,172	0				4.00
5.00	Fixed Equipment	502,503	0				5.00
6.00	Movable Equipment	81,585,521	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	192,688,961	0				8.00
9.00	Reconciling Items	-1,447,534	0				9.00
10.00	Total (line 8 minus line 9)	194,136,495	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-7
Part II
Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	11,874,493	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	11,874,493	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	11,874,493				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	11,874,493				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-7
Part III
Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	110,600,937	0	110,600,937	0.573987	119,225	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	82,088,024	0	82,088,024	0.426013	88,488	2.00
3.00	Total (sum of lines 1-2)	192,688,961	0	192,688,961	1.000000	207,713	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	119,225	4,220,329	741,813	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	88,488	7,622,018	0	2.00
3.00	Total (sum of lines 1-2)	0	0	207,713	11,842,347	741,813	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	119,225	502,306	204	5,583,877	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	88,488	0	0	7,710,506	2.00
3.00	Total (sum of lines 1-2)	0	207,713	502,306	204	13,294,383	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-8

Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-605,756	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-115,424	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-38,462,863			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-797,620	CAFETERIA	11.00	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	B	-1,675,431	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-96,963	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines	B	-1,042	CAFETERIA	11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet A-8

Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 DAYCARE RENT	B	-18,000	ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 DIETARY CATERING REVENUE	B	-6,467	DIETARY	10.00		0	33.01
33.02 RENTAL INCOME	B	-2,866	OPERATION OF PLANT	7.00		0	33.02
33.03 MISC INCOME - PHARMACY	B	-1,000	PHARMACY	15.00		0	33.03
33.04 MISC INCOME - A&G	B	-61,133	ADMINISTRATIVE & GENERAL	5.00		0	33.04
33.05 MISC INCOME - RT	B	-3,430	RESPIRATORY THERAPY	65.00		0	33.05
33.06		0		0.00		0	33.06
33.07 MISC INCOME - AMBULANCE	B	-1,523	AMBULANCE SERVICES	95.00		0	33.07
33.08		0		0.00		0	33.08
33.09 MISC INCOME - A&P	B	-69	ADULTS & PEDIATRICS	30.00		0	33.09
33.10 HOME NURSING INCOME	B	-1,107	HOME HEALTH AGENCY	101.00		0	33.10
33.11 CARDIAC REHAB PHASE III REVENUE	B	-17,190	ELECTROCARDIOLOGY	69.00		0	33.11
33.12		0		0.00		0	33.12
33.13 BLOOD DRAW INCOME	B	-1,055	HOME INFUSION	98.00		0	33.13
33.14 HOUSEKEEPING REVENUE	B	-394	HOUSEKEEPING	9.00		0	33.14
33.15 PATIENT ACCOUNTING REVENUE	B	-52,159	ADMINISTRATIVE & GENERAL	5.00		0	33.15
33.16 DAYCARE REVENUE	B	-493,995	ADMINISTRATIVE & GENERAL	5.00		0	33.16
33.17 DAYCARE DISCOUNT EXPENSE ELIMINATION	A	-33,346	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	33.17
33.18 FORGIVENESS OF DEBT	A	-6,522,749	ADMINISTRATIVE & GENERAL	5.00		0	33.18
34.00		0		0.00		0	34.00
35.00 LOBBYING EXPENSE	A	-38,091	ADMINISTRATIVE & GENERAL	5.00		0	35.00
36.00 PHYSICIAN RECRUITMENT SALARIES	A	-81,052	ADMINISTRATIVE & GENERAL	5.00		0	36.00
36.01 PHYSICIAN RECRUITMENT OTHER EXPENSES	A	-498,697	ADMINISTRATIVE & GENERAL	5.00		0	36.01
36.02 PHYSICIAN RECRUITMENT BENEFITS	A	-38,430	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	36.02
36.03 PHYSICIAN RECRUITMENT	A	-400	CAP REL COSTS-MVBLE EQUIP	2.00		9	36.03
37.00 MARKETING SALARIES	A	-238,613	ADMINISTRATIVE & GENERAL	5.00		0	37.00
37.01 MARKETING OTHER EXPENSES	A	-585,316	ADMINISTRATIVE & GENERAL	5.00		0	37.01
37.02 MARKETING DEPRECIATION	A	-27,109	CAP REL COSTS-MVBLE EQUIP	2.00		9	37.02
37.03 MARKETING BENEFITS	A	-82,836	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	37.03
38.00 CABLE TELEVISION	A	-38,935	ADMINISTRATIVE & GENERAL	5.00		0	38.00
38.01 CABLE TELEVISION	A	-2,950	CLINIC	90.00		0	38.01
39.00 CRNA SALARIES	A	-2,086,606	ANESTHESIOLOGY	53.00		0	39.00
39.01 CRNA LOCUM TENENS	A	-3,632	ANESTHESIOLOGY	53.00		0	39.01
39.02 CRNA MALPRACTICE INSURANCE	A	-29,942	ANESTHESIOLOGY	53.00		0	39.02
39.03 CRNA PHYSICIAN CME EXPENSE	A	-24,761	ANESTHESIOLOGY	53.00		0	39.03
39.04 CRNA FICA TAXES	A	-52,129	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	39.04
39.05 CRNA MEDICARE TAXES	A	-29,958	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	39.05
39.06 CRNA BENEFITS	A	-300,292	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	39.06
40.00 ALCOHOLIC BEVERAGE EXPENSE	A	-8,548	ADMINISTRATIVE & GENERAL	5.00		0	40.00
41.00 PHYSICIAN BENEFITS	A	-3,356,363	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	41.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-56,496,242					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: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet A-8-2 Date/Time Prepared: 9/26/2017 11:01 am	
Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours		
1.00	2.00	3.00	4.00	5.00	6.00	7.00		
1.00	5.00	171,500	0	171,500	211,500	1,143		1.00
2.00	15.00	36,663	36,663	0	0	0		2.00
3.00	30.00	2,832,181	2,832,181	0	0	0		3.00
4.00	31.00	36,498	36,498	0	0	0		4.00
5.00	53.00	43,650	43,650	0	0	0		5.00
6.00	53.01	746,541	746,541	0	0	0		6.00
7.00	54.00	1,257,160	1,257,160	0	0	0		7.00
8.00	54.01	496,785	496,785	0	0	0		8.00
9.00	56.00	56,704	56,704	0	0	0		9.00
10.00	57.00	1,593,915	1,593,915	0	0	0		10.00
11.00	58.00	584,427	584,427	0	0	0		11.00
12.00	60.00	510,487	510,487	0	0	0		12.00
13.00	70.00	3,017	3,017	0	0	0		13.00
14.00	76.98	332,701	332,701	0	0	0		14.00
15.00	90.00	25,090,295	25,090,295	0	0	0		15.00
16.00	91.00	4,786,562	4,786,562	0	0	0		16.00
200.00		38,579,086	38,407,586	171,500		1,143		200.00
Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance		
1.00	2.00	8.00	9.00	12.00	13.00	14.00		
1.00	5.00	116,223	5,811	0	0	0		1.00
2.00	15.00	0	0	0	0	0		2.00
3.00	30.00	0	0	35,349	0	101,272		3.00
4.00	31.00	0	0	0	0	36,498		4.00
5.00	53.00	0	0	0	0	0		5.00
6.00	53.01	0	0	0	0	11,378		6.00
7.00	54.00	0	0	0	0	0		7.00
8.00	54.01	0	0	0	0	0		8.00
9.00	56.00	0	0	0	0	0		9.00
10.00	57.00	0	0	0	0	0		10.00
11.00	58.00	0	0	0	0	0		11.00
12.00	60.00	0	0	7,118	0	7,419		12.00
13.00	70.00	0	0	0	0	3,017		13.00
14.00	76.98	0	0	0	0	8,177		14.00
15.00	90.00	0	0	185,884	0	800,580		15.00
16.00	91.00	0	0	0	0	0		16.00
200.00		116,223	5,811	228,351	0	968,341		200.00
Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment			
1.00	2.00	15.00	16.00	17.00	18.00			
1.00	5.00	0	116,223	55,277	55,277			1.00
2.00	15.00	0	0	0	36,663			2.00
3.00	30.00	0	0	0	2,832,181			3.00
4.00	31.00	0	0	0	36,498			4.00
5.00	53.00	0	0	0	43,650			5.00
6.00	53.01	0	0	0	746,541			6.00
7.00	54.00	0	0	0	1,257,160			7.00
8.00	54.01	0	0	0	496,785			8.00
9.00	56.00	0	0	0	56,704			9.00
10.00	57.00	0	0	0	1,593,915			10.00
11.00	58.00	0	0	0	584,427			11.00
12.00	60.00	0	0	0	510,487			12.00
13.00	70.00	0	0	0	3,017			13.00
14.00	76.98	0	0	0	332,701			14.00
15.00	90.00	0	0	0	25,090,295			15.00
16.00	91.00	0	0	0	4,786,562			16.00
200.00		0	116,223	55,277	38,462,863			200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet B Part I Date/Time Prepared: 9/26/2017 11:01 am
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,583,877	5,583,877			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	7,710,506		7,710,506		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	28,954,840	16,329	6,989	28,978,158	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,744,959	943,682	1,848,071	5,343,345	5.00
7.00 00700	OPERATION OF PLANT	3,846,899	179,936	31,168	562,634	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	399,413	69,173	20,586	120,106	8.00
9.00 00900	HOUSEKEEPING	2,188,886	7,192	21,612	486,190	9.00
10.00 01000	DIETARY	422,039	21,188	23,365	101,481	10.00
11.00 01100	CAFETERIA	591,093	68,717	75,766	329,127	11.00
13.00 01300	NURSING ADMINISTRATION	821,092	2,566	59,553	323,667	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	535,941	10,157	44,263	207,463	14.00
15.00 01500	PHARMACY	385,800	30,325	124,322	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,707,387	52,009	52,514	953,854	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,801,845	456,270	340,894	3,584,622	30.00
31.00 03100	INTENSIVE CARE UNIT	1,708,035	98,808	120,697	722,728	31.00
43.00 04300	NURSERY	468,090	83,782	46,320	213,676	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,974,937	236,649	675,203	773,447	50.00
51.00 05100	RECOVERY ROOM	843,803	129,347	64,990	388,952	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	856,443	101,899	84,612	390,953	52.00
53.00 05300	ANESTHESIOLOGY	49,164	6,220	4,937	0	53.00
53.01 05301	PAIN MANAGEMENT	241,358	29,158	27,477	100,039	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,083,721	172,967	799,502	717,982	54.00
54.01 05401	ULTRASOUND	678,173	28,517	92,149	237,494	54.01
56.00 05600	RADIOISOTOPE	395,633	66,996	164,173	141,461	56.00
57.00 05700	CT SCAN	725,200	18,564	157,980	301,382	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	552,680	39,140	49,550	189,011	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,000,526	76,395	613,635	301,105	59.00
60.00 06000	LABORATORY	4,602,120	115,477	295,891	1,124,592	60.00
65.00 06500	RESPIRATORY THERAPY	982,751	50,677	83,144	434,227	65.00
66.00 06600	PHYSICAL THERAPY	332,682	9,039	3,632	153,135	66.00
67.00 06700	OCCUPATIONAL THERAPY	75,285	3,898	0	34,992	67.00
68.00 06800	SPEECH PATHOLOGY	146,564	1,166	0	65,536	68.00
69.00 06900	ELECTROCARDIOLOGY	856,483	39,539	112,185	363,741	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	298,545	12,742	18,007	118,897	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,670,089	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	17,695,601	0	0	551,526	73.00
74.00 07400	RENAL DIALYSIS	131,931	1,944	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	GI LAB	1,146,601	34,203	251,385	464,234	75.01
76.00 03950	DIABETIC EDUCATION	271,834	15,114	3,279	77,619	76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	586,972	25,416	17,619	129,745	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	8,323,824	1,618,834	473,344	3,736,607	90.00
91.00 09100	EMERGENCY	3,545,677	202,748	758,160	1,628,830	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	1,714,003	30,694	76,092	734,515	95.00
98.00 09850	HOME INFUSION	174,039	2,041	0	31,883	98.00
101.00 10100	HOME HEALTH AGENCY	1,127,689	22,549	32,588	480,432	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	149,955,030	5,132,067	7,675,654	26,621,230	147,111,440
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	59,058	12,315	1,654	10,576	83,603
192.00 19200	PHYSICIANS' PRIVATE OFFICES	4,496,082	334,165	33,198	1,684,851	6,548,296
194.00 07950	COMMUNITY SERVICE	392,573	30,733	0	136,696	560,002
194.01 07951	OFFSITE FREESTANDING PT/OT	1,171,579	74,597	0	524,805	1,770,981
194.02 07952	OFFSITE BUILDINGS	141,191	0	0	0	141,191
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	156,215,513	5,583,877	7,710,506	28,978,158	156,215,513

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet B Part I Date/Time Prepared: 9/26/2017 11:01 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	28,880,057			5.00		
7.00	00700	OPERATION OF PLANT	1,047,974	5,668,611		7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	138,186	88,237	835,701	8.00		
9.00	00900	HOUSEKEEPING	613,248	9,175	64,745	3,391,048	9.00	
10.00	01000	DIETARY	128,841	27,028	3,651	16,451	744,044	10.00
11.00	01100	CAFETERIA	241,478	87,654	11,839	53,353	0	11.00
13.00	01300	NURSING ADMINISTRATION	273,724	3,273	0	1,992	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	180,949	12,956	0	7,886	0	14.00
15.00	01500	PHARMACY	122,575	38,682	0	23,545	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	854,087	66,342	0	40,380	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,763,284	582,011	318,431	354,256	691,023	30.00
31.00	03100	INTENSIVE CARE UNIT	601,089	126,038	38,473	76,716	53,021	31.00
43.00	04300	NURSERY	184,134	106,871	15,695	65,049	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	830,153	301,866	85,722	183,738	0	50.00
51.00	05100	RECOVERY ROOM	323,669	164,993	0	100,427	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	325,214	129,981	28,672	79,116	0	52.00
53.00	05300	ANESTHESIOLOGY	13,681	7,935	0	4,830	0	53.00
53.01	05301	PAIN MANAGEMENT	90,275	37,194	0	22,639	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	855,994	220,635	39,912	134,295	0	54.00
54.01	05401	ULTRASOUND	235,043	36,376	0	22,141	0	54.01
56.00	05600	RADIOISOTOPE	174,244	85,459	0	52,017	0	56.00
57.00	05700	CT SCAN	272,873	23,680	0	14,414	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	188,333	49,927	0	30,389	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	451,715	97,448	0	59,314	0	59.00
60.00	06000	LABORATORY	1,392,135	147,301	35	89,658	0	60.00
65.00	06500	RESPIRATORY THERAPY	351,726	64,643	0	39,347	0	65.00
66.00	06600	PHYSICAL THERAPY	113,059	11,530	0	7,018	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,895	4,972	0	3,026	0	67.00
68.00	06800	SPEECH PATHOLOGY	48,369	1,488	0	906	0	68.00
69.00	06900	ELECTROCARDIOLOGY	311,162	50,435	0	30,699	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	101,651	16,254	0	9,893	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,100,417	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,138,494	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	30,363	2,480	0	1,509	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	430,114	43,629	29,222	26,556	0	75.01
76.00	03950	DIABETIC EDUCATION	83,429	19,279	0	11,735	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	172,314	32,421	3,371	19,734	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,209,854	2,064,956	30,332	1,256,886	0	90.00
91.00	09100	EMERGENCY	1,391,531	258,622	124,510	157,417	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	579,551	39,153	18,166	23,831	0	95.00
98.00	09850	HOME INFUSION	47,167	2,604	0	1,585	0	98.00
101.00	10100	HOME HEALTH AGENCY	377,232	28,763	0	17,508	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,815,226	5,092,291	812,776	3,040,256	744,044	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,961	15,708	0	9,561	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,485,173	426,255	4,615	259,451	0	192.00
194.00	07950	COMMUNITY SERVICE	127,010	39,202	0	23,862	0	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	401,664	95,155	18,310	57,918	0	194.01
194.02	07952	OFFSITE BUILDINGS	32,023	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,880,057	5,668,611	835,701	3,391,048	744,044	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet B Part I Date/Time Prepared: 9/26/2017 11:01 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,459,027					11.00
13.00	01300	12,021	1,497,888				13.00
14.00	01400	15,472	0	1,015,087			14.00
15.00	01500	0	0	0	725,249		15.00
16.00	01600	68,807	0	0	0	4,795,380	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	228,423	379,136	1,660	0	275,862	30.00
31.00	03100	40,243	69,874	940	0	54,198	31.00
43.00	04300	9,611	16,676	0	0	23,639	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	38,145	66,232	5,351	0	341,052	50.00
51.00	05100	21,185	36,784	99	0	48,487	51.00
52.00	05200	17,570	30,512	0	0	43,252	52.00
53.00	05300	10,340	0	469	0	118,960	53.00
53.01	05301	7,096	9,739	1,323	0	40,198	53.01
54.00	05400	43,501	0	15	0	215,482	54.00
54.01	05401	10,935	0	0	0	111,396	54.01
56.00	05600	5,609	0	23	0	102,361	56.00
57.00	05700	15,487	0	0	0	430,312	57.00
58.00	05800	8,301	0	0	0	143,722	58.00
59.00	05900	14,996	26,038	489	0	166,434	59.00
60.00	06000	82,062	0	289	0	758,705	60.00
65.00	06500	23,208	0	782	0	56,071	65.00
66.00	06600	8,093	0	285	0	9,122	66.00
67.00	06700	1,175	0	0	0	1,947	67.00
68.00	06800	2,544	0	0	0	4,400	68.00
69.00	06900	23,089	40,091	742	0	164,768	69.00
70.00	07000	7,706	0	518	0	39,126	70.00
71.00	07100	0	0	954,312	0	167,092	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	25,812	0	0	725,249	410,597	73.00
74.00	07400	0	0	0	0	2,385	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	27,374	0	1,366	0	172,288	75.01
76.00	03950	5,177	0	864	0	3,977	76.00
76.98	07698	10,087	0	180	0	47,698	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	402,707	490,845	3,819	0	278,433	90.00
91.00	09100	96,969	168,370	936	0	394,506	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	51,713	0	0	0	41,406	95.00
98.00	09850	2,157	3,746	0	0	2,302	98.00
101.00	10100	22,658	39,341	99	0	10,396	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,360,273	1,377,384	974,561	725,249	4,680,574	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,473	0	250	0	0	190.00
192.00	19200	64,046	102,293	38,023	0	66,942	192.00
194.00	07950	7,141	18,211	79	0	0	194.00
194.01	07951	26,094	0	2,174	0	47,864	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,459,027	1,497,888	1,015,087	725,249	4,795,380	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet B
Part I
Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,777,717	0	17,777,717	30.00
31.00	03100	INTENSIVE CARE UNIT	3,710,860	0	3,710,860	31.00
43.00	04300	NURSERY	1,233,543	0	1,233,543	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,512,495	0	5,512,495	50.00
51.00	05100	RECOVERY ROOM	2,122,736	0	2,122,736	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,088,224	0	2,088,224	52.00
53.00	05300	ANESTHESIOLOGY	216,536	0	216,536	53.00
53.01	05301	PAIN MANAGEMENT	606,496	0	606,496	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,284,006	0	5,284,006	54.00
54.01	05401	ULTRASOUND	1,452,224	0	1,452,224	54.01
56.00	05600	RADIOISOTOPE	1,187,976	0	1,187,976	56.00
57.00	05700	CT SCAN	1,959,892	0	1,959,892	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,251,053	0	1,251,053	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,808,095	0	2,808,095	59.00
60.00	06000	LABORATORY	8,608,265	0	8,608,265	60.00
65.00	06500	RESPIRATORY THERAPY	2,086,576	0	2,086,576	65.00
66.00	06600	PHYSICAL THERAPY	647,595	0	647,595	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,190	0	151,190	67.00
68.00	06800	SPEECH PATHOLOGY	270,973	0	270,973	68.00
69.00	06900	ELECTROCARDIOLOGY	1,992,934	0	1,992,934	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	623,339	0	623,339	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,891,910	0	17,891,910	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,547,279	0	23,547,279	73.00
74.00	07400	RENAL DIALYSIS	170,612	0	170,612	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	2,626,972	0	2,626,972	75.01
76.00	03950	DIABETIC EDUCATION	492,307	0	492,307	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,045,557	0	1,045,557	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,890,441	0	21,890,441	90.00
91.00	09100	EMERGENCY	8,728,276	0	8,728,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,309,124	0	3,309,124	95.00
98.00	09850	HOME INFUSION	267,524	0	267,524	98.00
101.00	10100	HOME HEALTH AGENCY	2,159,255	0	2,159,255	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	143,721,982	0	143,721,982	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	129,556	0	129,556	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,995,094	0	8,995,094	192.00
194.00	07950	COMMUNITY SERVICE	775,507	0	775,507	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	2,420,160	0	2,420,160	194.01
194.02	07952	OFFSITE BUILDINGS	173,214	0	173,214	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	156,215,513	0	156,215,513	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet B Part II Date/Time Prepared: 9/26/2017 11:01 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	16,329	6,989	23,318	23,318 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	71,007	943,682	1,848,071	2,862,760	4,306 5.00
7.00 00700	OPERATION OF PLANT	5,256	179,936	31,168	216,360	453 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	69,173	20,586	89,759	97 8.00
9.00 00900	HOUSEKEEPING	0	7,192	21,612	28,804	391 9.00
10.00 01000	DIETARY	0	21,188	23,365	44,553	82 10.00
11.00 01100	CAFETERIA	0	68,717	75,766	144,483	265 11.00
13.00 01300	NURSING ADMINISTRATION	0	2,566	59,553	62,119	260 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	10,157	44,263	54,420	167 14.00
15.00 01500	PHARMACY	0	30,325	124,322	154,647	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	52,009	52,514	104,523	767 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	456,270	340,894	797,164	2,884 30.00
31.00 03100	INTENSIVE CARE UNIT	0	98,808	120,697	219,505	581 31.00
43.00 04300	NURSERY	0	83,782	46,320	130,102	172 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	70,705	236,649	675,203	982,557	622 50.00
51.00 05100	RECOVERY ROOM	0	129,347	64,990	194,337	313 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	101,899	84,612	186,511	314 52.00
53.00 05300	ANESTHESIOLOGY	0	6,220	4,937	11,157	0 53.00
53.01 05301	PAIN MANAGEMENT	0	29,158	27,477	56,635	80 53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	172,967	799,502	972,469	578 54.00
54.01 05401	ULTRASOUND	0	28,517	92,149	120,666	191 54.01
56.00 05600	RADIOLOGY-SOFT TISSUE	0	66,996	164,173	231,169	114 56.00
57.00 05700	CT SCAN	0	18,564	157,980	176,544	242 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	39,140	49,550	88,690	152 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	76,395	613,635	690,030	242 59.00
60.00 06000	LABORATORY	-5,103	115,477	295,891	406,265	905 60.00
65.00 06500	RESPIRATORY THERAPY	0	50,677	83,144	133,821	349 65.00
66.00 06600	PHYSICAL THERAPY	0	9,039	3,632	12,671	123 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	3,898	0	3,898	28 67.00
68.00 06800	SPEECH PATHOLOGY	0	1,166	0	1,166	53 68.00
69.00 06900	ELECTROCARDIOLOGY	0	39,539	112,185	151,724	293 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	717	12,742	18,007	31,466	96 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	444 73.00
74.00 07400	RENAL DIALYSIS	0	1,944	0	1,944	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01 07501	GI LAB	0	34,203	251,385	285,588	373 75.01
76.00 03950	DIABETIC EDUCATION	0	15,114	3,279	18,393	62 76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	25,416	17,619	43,035	104 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	1,618,834	473,344	2,092,178	3,006 90.00
91.00 09100	EMERGENCY	0	202,748	758,160	960,908	1,310 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	30,694	76,092	106,786	591 95.00
98.00 09850	HOME INFUSION	0	2,041	0	2,041	26 98.00
101.00 10100	HOME HEALTH AGENCY	0	22,549	32,588	55,137	386 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	142,582	5,132,067	7,675,654	12,950,303	21,422 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,315	1,654	13,969	9 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	334,165	33,198	367,363	1,355 192.00
194.00 07950	COMMUNITY SERVICE	0	30,733	0	30,733	110 194.00
194.01 07951	OFFSITE FREESTANDING PT/OT	0	74,597	0	74,597	422 194.01
194.02 07952	OFFSITE BUILDINGS	71,138	0	0	71,138	0 194.02
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	213,720	5,583,877	7,710,506	13,508,103	23,318 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0043

Period: From 05/01/2016 To 04/30/2017

Worksheet B Part II Date/Time Prepared: 9/26/2017 11:01 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,867,066				5.00
7.00	00700	OPERATION OF PLANT	104,038	320,851			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,719	4,994	108,569		8.00
9.00	00900	HOUSEKEEPING	60,881	519	8,411	99,006	9.00
10.00	01000	DIETARY	12,791	1,530	474	480	59,910
11.00	01100	CAFETERIA	23,973	4,961	1,538	1,558	0
13.00	01300	NURSING ADMINISTRATION	27,174	185	0	58	0
14.00	01400	CENTRAL SERVICES & SUPPLY	17,964	733	0	230	0
15.00	01500	PHARMACY	12,169	2,189	0	687	0
16.00	01600	MEDICAL RECORDS & LIBRARY	84,790	3,755	0	1,179	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	274,327	32,943	41,370	10,343	55,641
31.00	03100	INTENSIVE CARE UNIT	59,673	7,134	4,998	2,240	4,269
43.00	04300	NURSERY	18,280	6,049	2,039	1,899	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	82,414	17,086	11,136	5,364	0
51.00	05100	RECOVERY ROOM	32,132	9,339	0	2,932	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,286	7,357	3,725	2,310	0
53.00	05300	ANESTHESIOLOGY	1,358	449	0	141	0
53.01	05301	PAIN MANAGEMENT	8,962	2,105	0	661	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,979	12,488	5,185	3,921	0
54.01	05401	ULTRASOUND	23,334	2,059	0	646	0
56.00	05600	RADIOISOTOPE	17,298	4,837	0	1,519	0
57.00	05700	CT SCAN	27,090	1,340	0	421	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,697	2,826	0	887	0
59.00	05900	CARDIAC CATHETERIZATION	44,844	5,516	0	1,732	0
60.00	06000	LABORATORY	138,205	8,337	5	2,618	0
65.00	06500	RESPIRATORY THERAPY	34,918	3,659	0	1,149	0
66.00	06600	PHYSICAL THERAPY	11,224	653	0	205	0
67.00	06700	OCCUPATIONAL THERAPY	2,571	281	0	88	0
68.00	06800	SPEECH PATHOLOGY	4,802	84	0	26	0
69.00	06900	ELECTROCARDIOLOGY	30,891	2,855	0	896	0
70.00	07000	ELECTROENCEPHALOGRAPHY	10,091	920	0	289	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	307,796	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	410,834	0	0	0	0
74.00	07400	RENAL DIALYSIS	3,014	140	0	44	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	GI LAB	42,700	2,469	3,796	775	0
76.00	03950	DIABETIC EDUCATION	8,282	1,091	0	343	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	17,107	1,835	438	576	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	318,660	116,883	3,940	36,698	0
91.00	09100	EMERGENCY	138,145	14,638	16,175	4,596	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	57,535	2,216	2,360	696	0
98.00	09850	HOME INFUSION	4,682	147	0	46	0
101.00	10100	HOME HEALTH AGENCY	37,450	1,628	0	511	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,662,080	288,230	105,590	88,764	59,910
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,882	889	0	279	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	147,441	24,127	600	7,575	0
194.00	07950	COMMUNITY SERVICE	12,609	2,219	0	697	0
194.01	07951	OFFSITE FREESTANDING PT/OT	39,875	5,386	2,379	1,691	0
194.02	07952	OFFSITE BUILDINGS	3,179	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,867,066	320,851	108,569	99,006	59,910

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet B Part II Date/Time Prepared: 9/26/2017 11:01 am			
Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	176,778					11.00
13.00	01300	1,456	91,252				13.00
14.00	01400	1,875	0	75,389			14.00
15.00	01500	0	0	0	169,692		15.00
16.00	01600	8,337	0	0	0	203,351	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,676	23,097	123	0	11,701	30.00
31.00	03100	4,876	4,257	70	0	2,299	31.00
43.00	04300	1,164	1,016	0	0	1,003	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,622	4,035	397	0	14,466	50.00
51.00	05100	2,567	2,241	7	0	2,057	51.00
52.00	05200	2,129	1,859	0	0	1,835	52.00
53.00	05300	1,253	0	35	0	5,046	53.00
53.01	05301	860	593	98	0	1,705	53.01
54.00	05400	5,271	0	1	0	9,140	54.00
54.01	05401	1,325	0	0	0	4,725	54.01
56.00	05600	680	0	2	0	4,342	56.00
57.00	05700	1,876	0	0	0	18,252	57.00
58.00	05800	1,006	0	0	0	6,096	58.00
59.00	05900	1,817	1,586	36	0	7,059	59.00
60.00	06000	9,943	0	21	0	32,130	60.00
65.00	06500	2,812	0	58	0	2,378	65.00
66.00	06600	981	0	21	0	387	66.00
67.00	06700	142	0	0	0	83	67.00
68.00	06800	308	0	0	0	187	68.00
69.00	06900	2,798	2,442	55	0	6,989	69.00
70.00	07000	934	0	38	0	1,660	70.00
71.00	07100	0	0	70,877	0	7,087	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	3,127	0	0	169,692	17,416	73.00
74.00	07400	0	0	0	0	101	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	3,317	0	101	0	7,308	75.01
76.00	03950	627	0	64	0	169	76.00
76.98	07698	1,222	0	13	0	2,023	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	48,791	29,903	284	0	11,810	90.00
91.00	09100	11,749	10,257	70	0	16,733	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	6,266	0	0	0	1,756	95.00
98.00	09850	261	228	0	0	98	98.00
101.00	10100	2,745	2,397	7	0	441	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		164,813	83,911	72,378	169,692	198,482	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	178	0	19	0	0	190.00
192.00	19200	7,760	6,232	2,824	0	2,839	192.00
194.00	07950	865	1,109	6	0	0	194.00
194.01	07951	3,162	0	162	0	2,030	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		176,778	91,252	75,389	169,692	203,351	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet B Part II Date/Time Prepared: 9/26/2017 11:01 am
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,277,269	0	1,277,269	30.00
31.00	03100	INTENSIVE CARE UNIT	309,902	0	309,902	31.00
43.00	04300	NURSERY	161,724	0	161,724	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,122,699	0	1,122,699	50.00
51.00	05100	RECOVERY ROOM	245,925	0	245,925	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	238,326	0	238,326	52.00
53.00	05300	ANESTHESIOLOGY	19,439	0	19,439	53.00
53.01	05301	PAIN MANAGEMENT	71,699	0	71,699	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,094,032	0	1,094,032	54.00
54.01	05401	ULTRASOUND	152,946	0	152,946	54.01
56.00	05600	RADIOISOTOPE	259,961	0	259,961	56.00
57.00	05700	CT SCAN	225,765	0	225,765	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	118,354	0	118,354	58.00
59.00	05900	CARDIAC CATHETERIZATION	752,862	0	752,862	59.00
60.00	06000	LABORATORY	598,429	0	598,429	60.00
65.00	06500	RESPIRATORY THERAPY	179,144	0	179,144	65.00
66.00	06600	PHYSICAL THERAPY	26,265	0	26,265	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,091	0	7,091	67.00
68.00	06800	SPEECH PATHOLOGY	6,626	0	6,626	68.00
69.00	06900	ELECTROCARDIOLOGY	198,943	0	198,943	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	45,494	0	45,494	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	385,760	0	385,760	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	601,513	0	601,513	73.00
74.00	07400	RENAL DIALYSIS	5,243	0	5,243	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	GI LAB	346,427	0	346,427	75.01
76.00	03950	DIABETIC EDUCATION	29,031	0	29,031	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	66,353	0	66,353	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,662,153	0	2,662,153	90.00
91.00	09100	EMERGENCY	1,174,581	0	1,174,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	178,206	0	178,206	95.00
98.00	09850	HOME INFUSION	7,529	0	7,529	98.00
101.00	10100	HOME HEALTH AGENCY	100,702	0	100,702	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,670,393	0	12,670,393	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,225	0	17,225	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	568,116	0	568,116	192.00
194.00	07950	COMMUNITY SERVICE	48,348	0	48,348	194.00
194.01	07951	OFFSITE FREESTANDING PT/OT	129,704	0	129,704	194.01
194.02	07952	OFFSITE BUILDINGS	74,317	0	74,317	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,508,103	0	13,508,103	202.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet B-1 Date/Time Prepared: 9/26/2017 11:01 am
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	574,505				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		7,622,018			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,680	6,909	60,864,934		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	97,092	1,826,866	11,223,026	-28,880,057	5.00
7.00 00700	OPERATION OF PLANT	18,513	30,810	1,181,740	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	7,117	20,350	252,268	0	8.00
9.00 00900	HOUSEKEEPING	740	21,364	1,021,180	0	9.00
10.00 01000	DIETARY	2,180	23,097	213,147	0	10.00
11.00 01100	CAFETERIA	7,070	74,896	691,290	0	11.00
13.00 01300	NURSING ADMINISTRATION	264	58,870	679,822	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,045	43,755	435,749	0	14.00
15.00 01500	PHARMACY	3,120	122,895	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,351	51,911	2,003,449	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	46,944	336,982	7,529,042	0	30.00
31.00 03100	INTENSIVE CARE UNIT	10,166	119,312	1,517,998	0	31.00
43.00 04300	NURSERY	8,620	45,788	448,799	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	24,348	667,454	1,624,527	0	50.00
51.00 05100	RECOVERY ROOM	13,308	64,244	816,944	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,484	83,641	821,146	0	52.00
53.00 05300	ANESTHESIOLOGY	640	4,880	0	0	53.00
53.01 05301	PAIN MANAGEMENT	3,000	27,162	210,119	0	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,796	790,326	1,508,030	0	54.00
54.01 05401	ULTRASOUND	2,934	91,091	498,826	0	54.01
56.00 05600	RADIOISOTOPE	6,893	162,289	297,121	0	56.00
57.00 05700	CT SCAN	1,910	156,167	633,014	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,027	48,981	396,993	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	7,860	606,592	632,432	0	59.00
60.00 06000	LABORATORY	11,881	292,495	2,362,062	0	60.00
65.00 06500	RESPIRATORY THERAPY	5,214	82,190	912,038	0	65.00
66.00 06600	PHYSICAL THERAPY	930	3,590	321,641	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	401	0	73,497	0	67.00
68.00 06800	SPEECH PATHOLOGY	120	0	137,649	0	68.00
69.00 06900	ELECTROCARDIOLOGY	4,068	110,897	763,991	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,311	17,800	249,727	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	1,158,411	0	73.00
74.00 07400	RENAL DIALYSIS	200	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01 07501	GI LAB	3,519	248,500	975,064	0	75.01
76.00 03950	DIABETIC EDUCATION	1,555	3,241	163,028	0	76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	2,615	17,417	272,512	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	166,556	467,912	7,848,268	0	90.00
91.00 09100	EMERGENCY	20,860	749,459	3,421,150	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,158	75,219	1,542,756	0	95.00
98.00 09850	HOME INFUSION	210	0	66,967	0	98.00
101.00 10100	HOME HEALTH AGENCY	2,320	32,214	1,009,086	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	528,020	7,587,566	55,914,509	-28,880,057	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,267	1,635	22,213	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	34,381	32,817	3,538,815	0	192.00
194.00 07950	COMMUNITY SERVICE	3,162	0	287,112	0	194.00
194.01 07951	OFFSITE FREESTANDING PT/OT	7,675	0	1,102,285	0	194.01
194.02 07952	OFFSITE BUILDINGS	0	0	0	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	5,583,877	7,710,506	28,978,158		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.719458	1.011610	0.476106		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			23,318		204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet B-1
Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000383	5A	0.022516	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet B-1	
Date/Time Prepared: 9/26/2017 11:01 am							
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)		
	7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500	ADMINISTRATIVE & GENERAL						5.00
7.00 00700	OPERATION OF PLANT	457,220					7.00
8.00 00800	LAUNDRY & LINEN SERVICE	7,117	916,355				8.00
9.00 00900	HOUSEKEEPING	740	70,994	449,363			9.00
10.00 01000	DIETARY	2,180	4,003	2,180	49,172		10.00
11.00 01100	CAFETERIA	7,070	12,982	7,070	0	98,072	11.00
13.00 01300	NURSING ADMINISTRATION	264	0	264	0	808	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,045	0	1,045	0	1,040	14.00
15.00 01500	PHARMACY	3,120	0	3,120	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,351	0	5,351	0	4,625	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	46,944	349,165	46,944	45,668	15,354	30.00
31.00 03100	INTENSIVE CARE UNIT	10,166	42,186	10,166	3,504	2,705	31.00
43.00 04300	NURSERY	8,620	17,210	8,620	0	646	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	24,348	93,995	24,348	0	2,564	50.00
51.00 05100	RECOVERY ROOM	13,308	0	13,308	0	1,424	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,484	31,439	10,484	0	1,181	52.00
53.00 05300	ANESTHESIOLOGY	640	0	640	0	695	53.00
53.01 05301	PAIN MANAGEMENT	3,000	0	3,000	0	477	53.01
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,796	43,764	17,796	0	2,924	54.00
54.01 05401	ULTRASOUND	2,934	0	2,934	0	735	54.01
56.00 05600	RADIOISOTOPE	6,893	0	6,893	0	377	56.00
57.00 05700	CT SCAN	1,910	0	1,910	0	1,041	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,027	0	4,027	0	558	58.00
59.00 05900	CARDIAC CATHETERIZATION	7,860	0	7,860	0	1,008	59.00
60.00 06000	LABORATORY	11,881	38	11,881	0	5,516	60.00
65.00 06500	RESPIRATORY THERAPY	5,214	0	5,214	0	1,560	65.00
66.00 06600	PHYSICAL THERAPY	930	0	930	0	544	66.00
67.00 06700	OCCUPATIONAL THERAPY	401	0	401	0	79	67.00
68.00 06800	SPEECH PATHOLOGY	120	0	120	0	171	68.00
69.00 06900	ELECTROCARDIOLOGY	4,068	0	4,068	0	1,552	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,311	0	1,311	0	518	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,735	73.00
74.00 07400	RENAL DIALYSIS	200	0	200	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01 07501	GI LAB	3,519	32,042	3,519	0	1,840	75.01
76.00 03950	DIABETIC EDUCATION	1,555	0	1,555	0	348	76.00
76.98 07698	HYPERBARIC OXYGEN THERAPY	2,615	3,696	2,615	0	678	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	166,556	33,259	166,556	0	27,069	90.00
91.00 09100	EMERGENCY	20,860	136,526	20,860	0	6,518	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	3,158	19,919	3,158	0	3,476	95.00
98.00 09850	HOME INFUSION	210	0	210	0	145	98.00
101.00 10100	HOME HEALTH AGENCY	2,320	0	2,320	0	1,523	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	410,735	891,218	402,878	49,172	91,434	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,267	0	1,267	0	99	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	34,381	5,060	34,381	0	4,305	192.00
194.00 07950	COMMUNITY SERVICE	3,162	0	3,162	0	480	194.00
194.01 07951	OFFSITE FREESTANDING PT/OT	7,675	20,077	7,675	0	1,754	194.01
194.02 07952	OFFSITE BUILDINGS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	5,668,611	835,701	3,391,048	744,044	1,459,027	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.397994	0.911984	7.546344	15.131457	14.877100	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	320,851	108,569	99,006	59,910	176,778	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.701743	0.118479	0.220325	1.218376	1.802533	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet B-1

Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description		NURSING ADMINISTRATIVE (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	1,206,123				13.00
14.00	01400	0	14,540,671			14.00
15.00	01500	0	0	18,212,621		15.00
16.00	01600	0	0	0	620,102,084	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	305,286	23,781	0	35,673,401	30.00
31.00	03100	56,264	13,458	0	7,008,627	31.00
43.00	04300	13,428	0	0	3,056,924	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	53,331	76,658	0	44,103,485	50.00
51.00	05100	29,619	1,412	0	6,270,092	51.00
52.00	05200	24,569	0	0	5,593,111	52.00
53.00	05300	0	6,716	0	15,383,434	53.00
53.01	05301	7,842	18,950	0	5,198,213	53.01
54.00	05400	0	214	0	27,865,270	54.00
54.01	05401	0	0	0	14,405,322	54.01
56.00	05600	0	328	0	13,236,872	56.00
57.00	05700	0	0	0	55,646,184	57.00
58.00	05800	0	0	0	18,585,501	58.00
59.00	05900	20,966	7,007	0	21,522,568	59.00
60.00	06000	0	4,143	0	98,095,710	60.00
65.00	06500	0	11,199	0	7,250,923	65.00
66.00	06600	0	4,076	0	1,179,678	66.00
67.00	06700	0	0	0	251,768	67.00
68.00	06800	0	0	0	568,999	68.00
69.00	06900	32,282	10,631	0	21,307,164	69.00
70.00	07000	0	7,418	0	5,059,576	70.00
71.00	07100	0	13,670,089	0	21,607,649	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	18,212,621	53,096,711	73.00
74.00	07400	0	0	0	308,417	74.00
75.00	07500	0	0	0	0	75.00
75.01	07501	0	19,573	0	22,279,593	75.01
76.00	03950	0	12,375	0	514,281	76.00
76.98	07698	0	2,583	0	6,168,063	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	395,236	54,711	0	36,005,788	90.00
91.00	09100	135,574	13,408	0	51,015,935	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	0	0	5,354,445	95.00
98.00	09850	3,016	0	0	297,715	98.00
101.00	10100	31,678	1,415	0	1,344,420	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00						118.00
SUBTOTALS (SUM OF LINES 1-117)		1,109,091	13,960,145	18,212,621	605,255,839	
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	3,588	0	0	190.00
192.00	19200	82,368	544,660	0	8,656,723	192.00
194.00	07950	14,664	1,130	0	0	194.00
194.01	07951	0	31,148	0	6,189,522	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		1,497,888	1,015,087	725,249	4,795,380	202.00
203.00		1.241903	0.069810	0.039821	0.007733	203.00
204.00		91,252	75,389	169,692	203,351	204.00
205.00		0.075657	0.005185	0.009317	0.000328	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet C
Part I
Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
Title XVIII Hospital PPS						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	17,777,717		17,777,717	0	17,777,717 30.00
31.00	03100 INTENSIVE CARE UNIT	3,710,860		3,710,860	0	3,710,860 31.00
43.00	04300 NURSERY	1,233,543		1,233,543	0	1,233,543 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,512,495		5,512,495	0	5,512,495 50.00
51.00	05100 RECOVERY ROOM	2,122,736		2,122,736	0	2,122,736 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,088,224		2,088,224	0	2,088,224 52.00
53.00	05300 ANESTHESIOLOGY	216,536		216,536	0	216,536 53.00
53.01	05301 PAIN MANAGEMENT	606,496		606,496	0	606,496 53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,284,006		5,284,006	0	5,284,006 54.00
54.01	05401 ULTRASOUND	1,452,224		1,452,224	0	1,452,224 54.01
56.00	05600 RADIO SOTOP	1,187,976		1,187,976	0	1,187,976 56.00
57.00	05700 CT SCAN	1,959,892		1,959,892	0	1,959,892 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,251,053		1,251,053	0	1,251,053 58.00
59.00	05900 CARDIAC CATHETERIZATION	2,808,095		2,808,095	0	2,808,095 59.00
60.00	06000 LABORATORY	8,608,265		8,608,265	0	8,608,265 60.00
65.00	06500 RESPIRATORY THERAPY	2,086,576	0	2,086,576	0	2,086,576 65.00
66.00	06600 PHYSICAL THERAPY	647,595	0	647,595	0	647,595 66.00
67.00	06700 OCCUPATIONAL THERAPY	151,190	0	151,190	0	151,190 67.00
68.00	06800 SPEECH PATHOLOGY	270,973	0	270,973	0	270,973 68.00
69.00	06900 ELECTROCARDIOLOGY	1,992,934		1,992,934	0	1,992,934 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	623,339		623,339	0	623,339 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,891,910		17,891,910	0	17,891,910 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	23,547,279		23,547,279	0	23,547,279 73.00
74.00	07400 RENAL DIALYSIS	170,612		170,612	0	170,612 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0 75.00
75.01	07501 GI LAB	2,626,972		2,626,972	0	2,626,972 75.01
76.00	03950 DIABETIC EDUCATION	492,307		492,307	0	492,307 76.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,045,557		1,045,557	0	1,045,557 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	21,890,441		21,890,441	0	21,890,441 90.00
91.00	09100 EMERGENCY	8,728,276		8,728,276	0	8,728,276 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,975,356		3,975,356	0	3,975,356 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	3,309,124		3,309,124	0	3,309,124 95.00
98.00	09850 HOME INFUSION	267,524		267,524	0	267,524 98.00
101.00	10100 HOME HEALTH AGENCY	2,159,255		2,159,255	0	2,159,255 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	147,697,338	0	147,697,338	0	147,697,338 200.00
201.00	Less Observation Beds	3,975,356		3,975,356		3,975,356 201.00
202.00	Total (see instructions)	143,721,982	0	143,721,982	0	143,721,982 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet C Part I Date/Time Prepared: 9/26/2017 11:01 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	29,645,413		29,645,413				30.00
31.00	03100	INTENSIVE CARE UNIT	7,008,627		7,008,627				31.00
43.00	04300	NURSERY	3,056,924		3,056,924				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	15,424,461	28,679,024	44,103,485	0.124990	0.000000		50.00
51.00	05100	RECOVERY ROOM	1,523,073	4,747,019	6,270,092	0.338549	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,831,762	1,761,349	5,593,111	0.373356	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	6,711,935	8,671,499	15,383,434	0.014076	0.000000		53.00
53.01	05301	PAIN MANAGEMENT	292	5,197,921	5,198,213	0.116674	0.000000		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,194,479	24,670,791	27,865,270	0.189627	0.000000		54.00
54.01	05401	ULTRASOUND	1,298,615	13,106,707	14,405,322	0.100812	0.000000		54.01
56.00	05600	RADIOISOTOPE	977,743	12,259,129	13,236,872	0.089747	0.000000		56.00
57.00	05700	CT SCAN	10,286,846	45,359,338	55,646,184	0.035221	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,365,771	17,219,730	18,585,501	0.067313	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	8,050,197	13,472,371	21,522,568	0.130472	0.000000		59.00
60.00	06000	LABORATORY	20,138,357	77,957,353	98,095,710	0.087754	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	4,852,219	2,398,704	7,250,923	0.287767	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,037,045	142,633	1,179,678	0.548959	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	132,184	119,584	251,768	0.600513	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	120,677	448,322	568,999	0.476228	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	4,404,313	16,902,851	21,307,164	0.093534	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	147,884	4,911,692	5,059,576	0.123200	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,539,499	11,068,150	21,607,649	0.828036	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,097,680	36,999,031	53,096,711	0.443479	0.000000		73.00
74.00	07400	RENAL DIALYSIS	293,302	15,115	308,417	0.553186	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
75.01	07501	GI LAB	1,823,441	20,456,152	22,279,593	0.117909	0.000000		75.01
76.00	03950	DIABETIC EDUCATION	0	514,281	514,281	0.957272	0.000000		76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	47,727	6,120,336	6,168,063	0.169511	0.000000		76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	79,363	35,926,425	36,005,788	0.607970	0.000000		90.00
91.00	09100	EMERGENCY	9,894,448	41,121,487	51,015,935	0.171089	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	607,615	5,420,373	6,027,988	0.659483	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	5,354,445	5,354,445	0.618014	0.000000		95.00
98.00	09850	HOME INFUSION	0	297,715	297,715	0.898591	0.000000		98.00
101.00	10100	HOME HEALTH AGENCY	0	1,344,420	1,344,420				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	162,591,892	442,663,947	605,255,839				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	162,591,892	442,663,947	605,255,839				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet C Part I Date/Time Prepared: 9/26/2017 11:01 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		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	0.124990		50.00
51.00	05100 RECOVERY ROOM	0.338549		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.373356		52.00
53.00	05300 ANESTHESIOLOGY	0.014076		53.00
53.01	05301 PAIN MANAGEMENT	0.116674		53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.189627		54.00
54.01	05401 ULTRASOUND	0.100812		54.01
56.00	05600 RADIOISOTOPE	0.089747		56.00
57.00	05700 CT SCAN	0.035221		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.067313		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.130472		59.00
60.00	06000 LABORATORY	0.087754		60.00
65.00	06500 RESPIRATORY THERAPY	0.287767		65.00
66.00	06600 PHYSICAL THERAPY	0.548959		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.600513		67.00
68.00	06800 SPEECH PATHOLOGY	0.476228		68.00
69.00	06900 ELECTROCARDIOLOGY	0.093534		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.123200		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.828036		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.443479		73.00
74.00	07400 RENAL DIALYSIS	0.553186		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
75.01	07501 GI LAB	0.117909		75.01
76.00	03950 DIABETIC EDUCATION	0.957272		76.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.169511		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.607970		90.00
91.00	09100 EMERGENCY	0.171089		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.659483		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.618014		95.00
98.00	09850 HOME INFUSION	0.898591		98.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet D Part I Date/Time Prepared: 9/26/2017 11:01 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,277,269	0	1,277,269	15,169	84.20	30.00
31.00	INTENSIVE CARE UNIT	309,902		309,902	1,391	222.79	31.00
43.00	NURSERY	161,724		161,724	1,009	160.28	43.00
200.00	Total (Lines 30-199)	1,748,895		1,748,895	17,569		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	6,626	557,909				
31.00	INTENSIVE CARE UNIT	880	196,055				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	7,506	753,964				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part II Date/Time Prepared: 9/26/2017 11:01 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,122,699	44,103,485	0.025456	6,672,700	169,860	50.00
51.00	05100	RECOVERY ROOM	245,925	6,270,092	0.039222	748,465	29,356	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	238,326	5,593,111	0.042611	29,888	1,274	52.00
53.00	05300	ANESTHESIOLOGY	19,439	15,383,434	0.001264	3,077,777	3,890	53.00
53.01	05301	PAIN MANAGEMENT	71,699	5,198,213	0.013793	208	3	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,094,032	27,865,270	0.039261	1,979,215	77,706	54.00
54.01	05401	ULTRASOUND	152,946	14,405,322	0.010617	765,714	8,130	54.01
56.00	05600	RADIOLOGY-SOFT	259,961	13,236,872	0.019639	576,024	11,313	56.00
57.00	05700	CT SCAN	225,765	55,646,184	0.004057	6,057,781	24,576	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	118,354	18,585,501	0.006368	747,855	4,762	58.00
59.00	05900	CARDIAC CATHETERIZATION	752,862	21,522,568	0.034980	3,532,087	123,552	59.00
60.00	06000	LABORATORY	598,429	98,095,710	0.006100	11,924,633	72,740	60.00
65.00	06500	RESPIRATORY THERAPY	179,144	7,250,923	0.024706	3,245,589	80,186	65.00
66.00	06600	PHYSICAL THERAPY	26,265	1,179,678	0.022265	695,590	15,487	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,091	251,768	0.028165	72,788	2,050	67.00
68.00	06800	SPEECH PATHOLOGY	6,626	568,999	0.011645	77,591	904	68.00
69.00	06900	ELECTROCARDIOLOGY	198,943	21,307,164	0.009337	2,735,911	25,545	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	45,494	5,059,576	0.008992	95,070	855	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	385,760	21,607,649	0.017853	5,429,601	96,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	601,513	53,096,711	0.011329	8,860,765	100,384	73.00
74.00	07400	RENAL DIALYSIS	5,243	308,417	0.017000	221,010	3,757	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	GI LAB	346,427	22,279,593	0.015549	1,188,984	18,488	75.01
76.00	03950	DIABETIC EDUCATION	29,031	514,281	0.056450	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	66,353	6,168,063	0.010758	30,757	331	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,662,153	36,005,788	0.073937	52,119	3,854	90.00
91.00	09100	EMERGENCY	1,174,581	51,015,935	0.023024	5,937,038	136,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	285,617	6,027,988	0.047382	370,994	17,578	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	HOME INFUSION	7,529	297,715	0.025289	0	0	98.00
200.00		Total (lines 50-199)	10,928,207	558,846,010		65,126,154	1,030,210	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet D Part III Date/Time Prepared: 9/26/2017 11:01 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,169	0.00	6,626	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,391	0.00	880	0		31.00
43.00	04300	NURSERY	1,009	0.00	0	0		43.00
200.00		Total (lines 30-199)	17,569		7,506	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet D
Part IV
Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description		Title XVIII				Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	GI LAB	0	0	0	0	0	75.01
76.00	03950	DIABETIC EDUCATION	0	0	0	0	0	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	HOME INFUSION	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part IV Date/Time Prepared: 9/26/2017 11:01 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	44,103,485	0.000000	0.000000	6,672,700	50.00
51.00	05100 RECOVERY ROOM	0	6,270,092	0.000000	0.000000	748,465	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5,593,111	0.000000	0.000000	29,888	52.00
53.00	05300 ANESTHESIOLOGY	0	15,383,434	0.000000	0.000000	3,077,777	53.00
53.01	05301 PAIN MANAGEMENT	0	5,198,213	0.000000	0.000000	208	53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	27,865,270	0.000000	0.000000	1,979,215	54.00
54.01	05401 ULTRASOUND	0	14,405,322	0.000000	0.000000	765,714	54.01
56.00	05600 RADIOISOTOPE	0	13,236,872	0.000000	0.000000	576,024	56.00
57.00	05700 CT SCAN	0	55,646,184	0.000000	0.000000	6,057,781	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	18,585,501	0.000000	0.000000	747,855	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	21,522,568	0.000000	0.000000	3,532,087	59.00
60.00	06000 LABORATORY	0	98,095,710	0.000000	0.000000	11,924,633	60.00
65.00	06500 RESPIRATORY THERAPY	0	7,250,923	0.000000	0.000000	3,245,589	65.00
66.00	06600 PHYSICAL THERAPY	0	1,179,678	0.000000	0.000000	695,590	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	251,768	0.000000	0.000000	72,788	67.00
68.00	06800 SPEECH PATHOLOGY	0	568,999	0.000000	0.000000	77,591	68.00
69.00	06900 ELECTROCARDIOLOGY	0	21,307,164	0.000000	0.000000	2,735,911	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	5,059,576	0.000000	0.000000	95,070	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,607,649	0.000000	0.000000	5,429,601	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	53,096,711	0.000000	0.000000	8,860,765	73.00
74.00	07400 RENAL DIALYSIS	0	308,417	0.000000	0.000000	221,010	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501 GI LAB	0	22,279,593	0.000000	0.000000	1,188,984	75.01
76.00	03950 DIABETIC EDUCATION	0	514,281	0.000000	0.000000	0	76.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	6,168,063	0.000000	0.000000	30,757	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	36,005,788	0.000000	0.000000	52,119	90.00
91.00	09100 EMERGENCY	0	51,015,935	0.000000	0.000000	5,937,038	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	6,027,988	0.000000	0.000000	370,994	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	09850 HOME INFUSION	0	297,715	0.000000	0.000000	0	98.00
200.00	Total (lines 50-199)	0	558,846,010			65,126,154	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part IV Date/Time Prepared: 9/26/2017 11:01 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
Title XVIII		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	9,266,959	0		50.00
51.00	05100 RECOVERY ROOM	0	1,565,662	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	2,305,945	0		53.00
53.01	05301 PAIN MANAGEMENT	0	1,793,238	0		53.01
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,250,398	0		54.00
54.01	05401 ULTRASOUND	0	3,407,594	0		54.01
56.00	05600 RADIOISOTOPE	0	4,746,707	0		56.00
57.00	05700 CT SCAN	0	16,319,255	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4,925,488	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	6,179,485	0		59.00
60.00	06000 LABORATORY	0	15,328,191	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	953,146	0		65.00
66.00	06600 PHYSICAL THERAPY	0	74,827	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	3,932	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	3,414	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	5,685,393	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,653,279	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,226,295	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10,983,914	0		73.00
74.00	07400 RENAL DIALYSIS	0	9,342	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01	07501 GI LAB	0	6,717,021	0		75.01
76.00	03950 DIABETIC EDUCATION	0	38,560	0		76.00
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	3,119,325	0		76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	17,211,150	0		90.00
91.00	09100 EMERGENCY	0	10,856,602	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,268,217	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
98.00	09850 HOME INFUSION	0	0	0		98.00
200.00	Total (lines 50-199)	0	136,893,339	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part V Date/Time Prepared: 9/26/2017 11:01 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.124990	9,266,959	0	0	1,158,277	50.00
51.00	05100	RECOVERY ROOM	0.338549	1,565,662	0	0	530,053	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.373356	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.014076	2,305,945	0	0	32,458	53.00
53.01	05301	PAIN MANAGEMENT	0.116674	1,793,238	0	0	209,224	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189627	7,250,398	0	0	1,374,871	54.00
54.01	05401	ULTRASOUND	0.100812	3,407,594	0	0	343,526	54.01
56.00	05600	RADIOISOTOPE	0.089747	4,746,707	0	0	426,003	56.00
57.00	05700	CT SCAN	0.035221	16,319,255	0	0	574,780	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067313	4,925,488	0	0	331,549	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.130472	6,179,485	0	0	806,250	59.00
60.00	06000	LABORATORY	0.087754	15,328,191	14,192	0	1,345,110	60.00
65.00	06500	RESPIRATORY THERAPY	0.287767	953,146	0	0	274,284	65.00
66.00	06600	PHYSICAL THERAPY	0.548959	74,827	0	0	41,077	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.600513	3,932	0	0	2,361	67.00
68.00	06800	SPEECH PATHOLOGY	0.476228	3,414	0	0	1,626	68.00
69.00	06900	ELECTROCARDIOLOGY	0.093534	5,685,393	0	0	531,778	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.123200	1,653,279	0	0	203,684	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.828036	4,226,295	0	0	3,499,524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.443479	10,983,914	1,356	218,693	4,871,135	73.00
74.00	07400	RENAL DIALYSIS	0.553186	9,342	0	0	5,168	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	07501	GI LAB	0.117909	6,717,021	0	0	791,997	75.01
76.00	03950	DIABETIC EDUCATION	0.957272	38,560	0	0	36,912	76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.169511	3,119,325	0	0	528,760	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.607970	17,211,150	0	0	10,463,863	90.00
91.00	09100	EMERGENCY	0.171089	10,856,602	0	0	1,857,445	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.659483	2,268,217	0	0	1,495,851	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.618014		0	0		95.00
98.00	09850	HOME INFUSION	0.898591	0	0	0	0	98.00
200.00		Subtotal (see instructions)		136,893,339	15,548	218,693	31,737,566	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		136,893,339	15,548	218,693	31,737,566	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet D Part V Date/Time Prepared: 9/26/2017 11:01 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
53.01 05301 PAIN MANAGEMENT	0	0		53.01
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRASOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	1,245	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	601	96,986		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01 07501 GI LAB	0	0		75.01
76.00 03950 DIABETIC EDUCATION	0	0		76.00
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
98.00 09850 HOME INFUSION	0	0		98.00
200.00	Subtotal (see instructions)	1,846	96,986	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,846	96,986	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet D-1 Date/Time Prepared: 9/26/2017 11:01 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,169	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,169	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)		11,777	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,626	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		17,777,717	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		17,777,717	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)		17,777,717	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)		1,171.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,765,539	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)		7,765,539	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet D-1 Date/Time Prepared: 9/26/2017 11:01 am
Title XVIII			Hospital	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	3,710,860	1,391	2,667.76	880	2,347,629	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					15,066,439	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,179,607	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)					753,964	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,030,210	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,784,174	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,395,433	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					3,392	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,171.98	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,975,356	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0043		Period: From 05/01/2016 To 04/30/2017		Worksheet D-1 Date/Time Prepared: 9/26/2017 11:01 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,277,269	17,777,717	0.071847	3,975,356	285,617	90.00
91.00	Nursing School cost	0	17,777,717	0.000000	3,975,356	0	91.00
92.00	Allied health cost	0	17,777,717	0.000000	3,975,356	0	92.00
93.00	All other Medical Education	0	17,777,717	0.000000	3,975,356	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet D-3 Date/Time Prepared: 9/26/2017 11:01 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		12,208,206	30.00
31.00	03100	INTENSIVE CARE UNIT		3,977,857	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.124990	6,672,700	834,021 50.00
51.00	05100	RECOVERY ROOM	0.338549	748,465	253,392 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.373356	29,888	11,159 52.00
53.00	05300	ANESTHESIOLOGY	0.014076	3,077,777	43,323 53.00
53.01	05301	PAIN MANAGEMENT	0.116674	208	24 53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189627	1,979,215	375,313 54.00
54.01	05401	ULTRASOUND	0.100812	765,714	77,193 54.01
56.00	05600	RADIOISOTOPE	0.089747	576,024	51,696 56.00
57.00	05700	CT SCAN	0.035221	6,057,781	213,361 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067313	747,855	50,340 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.130472	3,532,087	460,838 59.00
60.00	06000	LABORATORY	0.087754	11,924,633	1,046,434 60.00
65.00	06500	RESPIRATORY THERAPY	0.287767	3,245,589	933,973 65.00
66.00	06600	PHYSICAL THERAPY	0.548959	695,590	381,850 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.600513	72,788	43,710 67.00
68.00	06800	SPEECH PATHOLOGY	0.476228	77,591	36,951 68.00
69.00	06900	ELECTROCARDIOLOGY	0.093534	2,735,911	255,901 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.123200	95,070	11,713 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.828036	5,429,601	4,495,905 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.443479	8,860,765	3,929,563 73.00
74.00	07400	RENAL DIALYSIS	0.553186	221,010	122,260 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
75.01	07501	GI LAB	0.117909	1,188,984	140,192 75.01
76.00	03950	DIABETIC EDUCATION	0.957272	0	0 76.00
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.169511	30,757	5,214 76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.607970	52,119	31,687 90.00
91.00	09100	EMERGENCY	0.171089	5,937,038	1,015,762 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.659483	370,994	244,664 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
98.00	09850	HOME INFUSION	0.898591	0	0 98.00
200.00		Total (sum of lines 50-94 and 96-98)		65,126,154	15,066,439 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		65,126,154	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part A Date/Time Prepared: 9/26/2017 11:01 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		5,877,281	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,297,526	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		366,370	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		146,720	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		87.71	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.52	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.72	31.00
32.00	Sum of lines 30 and 31		23.24	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.39	33.00
34.00	Disproportionate share adjustment (see instructions)		318,292	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part A Date/Time Prepared: 9/26/2017 11:01 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)		0.000092992	0.000090416	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		595,721	540,461	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		249,031	313,912	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		562,943		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		16,422,412		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		18,577,442		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			18,038,685	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,245,975	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			4,143	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			19,288,803	59.00
60.00	Primary payer payments			7,177	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			19,281,626	61.00
62.00	Deductibles billed to program beneficiaries			1,925,644	62.00
63.00	Coinsurance billed to program beneficiaries			16,128	63.00
64.00	Allowable bad debts (see instructions)			475,867	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			309,314	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			365,521	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			17,649,168	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	RURAL DEMONSTRATION PROJECT			0	70.50
70.88	SCH or MDH volume decrease adjustment			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			3,136	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			26,875	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part A Date/Time Prepared: 9/26/2017 11:01 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,679,179		71.00
71.01	Sequestration adjustment (see instructions)		353,584		71.01
72.00	Interim payments		17,501,558		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-175,963		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		677,506	938,767	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0050316581	0.9997087410	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		3,409	-273	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		1.0000	1.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet E Part B Date/Time Prepared: 9/26/2017 11:01 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		98,832	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		31,737,566	2.00
3.00	PPS payments		23,828,365	3.00
4.00	Outlier payment (see instructions)		773,415	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)		98,832	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		234,241	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)		234,241	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)		234,241	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		135,409	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)		98,832	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)		24,601,780	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		5,069,955	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)		19,630,657	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)		19,630,657	30.00
31.00	Primary payer payments		420	31.00
32.00	Subtotal (line 30 minus line 31)		19,630,237	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)		872,591	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		567,184	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		455,787	36.00
37.00	Subtotal (see instructions)		20,197,421	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-27	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)		20,197,448	40.00
40.01	Sequestration adjustment (see instructions)		403,949	40.01
41.00	Interim payments		19,895,079	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-101,580	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: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
9/26/2017 11:01 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		17,512,275		19,850,371	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	12/01/2016	44,708	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	12/01/2016	10,717		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)		-10,717		44,708	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)		17,501,558		19,895,079	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		175,963		101,580	6.02	
7.00	Total Medicare program liability (see instructions)		17,325,595		19,793,499	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0043 Component CCN: 14-U043		Period: From 05/01/2016 To 04/30/2017		Worksheet E-1 Part I Date/Time Prepared: 9/26/2017 11:01 am	
		Title XVIII		Swing Beds - SNF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		0		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet E-1 Part II Date/Time Prepared: 9/26/2017 11:01 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		4,068	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		7,506	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		922	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		13,168	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		605,255,839	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		3,286,716	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 IPSS & 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: 14-0043 Component CCN: 14-U043	Period: From 05/01/2016 To 04/30/2017	Worksheet E-2 Date/Time Prepared: 9/26/2017 11:01 am	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)				3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		0	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		0	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
20.00	Interim payments		0	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00

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

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet G

Date/Time Prepared:
9/26/2017 11:01 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	44,869,749	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	32,823,505	0	0	0	4.00
5.00	Other receivable	1,328,651	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,854,363	0	0	0	7.00
8.00	Prepaid expenses	2,587,172	0	0	0	8.00
9.00	Other current assets	2,033,329	0	0	0	9.00
10.00	Due from other funds	169,179	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	87,665,948	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,724,440	0	0	0	12.00
13.00	Land improvements	4,160,839	0	0	0	13.00
14.00	Accumulated depreciation	-2,562,381	0	0	0	14.00
15.00	Buildings	90,086,486	0	0	0	15.00
16.00	Accumulated depreciation	-51,655,720	0	0	0	16.00
17.00	Leasehold improvements	13,629,172	0	0	0	17.00
18.00	Accumulated depreciation	-11,949,081	0	0	0	18.00
19.00	Fixed equipment	502,503	0	0	0	19.00
20.00	Accumulated depreciation	-371,492	0	0	0	20.00
21.00	Automobiles and trucks	531,789	0	0	0	21.00
22.00	Accumulated depreciation	-460,189	0	0	0	22.00
23.00	Major movable equipment	66,108,211	0	0	0	23.00
24.00	Accumulated depreciation	-45,994,873	0	0	0	24.00
25.00	Minor equipment depreciable	14,945,521	0	0	0	25.00
26.00	Accumulated depreciation	-12,357,622	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	1,447,534	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	68,785,137	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	51,250,014	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	20,709,457	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	71,959,471	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	228,410,556	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,082,119	0	0	0	37.00
38.00	Salaries, wages, and fees payable	11,093,679	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,750,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	14,881,684	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,807,482	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,350,615	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	62,360,701	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	78,711,316	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	111,518,798	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	116,891,758				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)	116,891,758	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	228,410,556	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet G-1

Date/Time Prepared:
9/26/2017 11:01 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		107,979,942		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,911,816				2.00
3.00	Total (sum of line 1 and line 2)		116,891,758		0		3.00
4.00		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)		116,891,758		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		116,891,758		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			0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/26/2017 11:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	32,702,337		32,702,337	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	32,702,337		32,702,337	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,008,627		7,008,627	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	7,008,627		7,008,627	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,710,964		39,710,964	17.00
18.00	Ancillary services	112,299,502	353,199,082	465,498,584	18.00
19.00	Outpatient services	10,581,426	82,468,285	93,049,711	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,344,420	1,344,420	22.00
23.00	AMBULANCE SERVICES	0	5,354,445	5,354,445	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	4,117,866	140,948,990	145,066,856	27.00
27.01	PHYSICIANS' PRIVATE OFFICES	0	8,656,723	8,656,723	27.01
27.02	PT/OT/ST NON-PROVIDER BASED	0	6,189,522	6,189,522	27.02
27.03	HOME INFUSION	0	297,715	297,715	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	166,709,758	598,459,182	765,168,940	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		212,711,755		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	INTEREST EXPENSE	605,756			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)		605,756		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		212,105,999		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0043

Period:
From 05/01/2016
To 04/30/2017

Worksheet G-3

Date/Time Prepared:
9/26/2017 11:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	765,168,940	1.00
2.00	Less contractual allowances and discounts on patients' accounts	555,351,123	2.00
3.00	Net patient revenues (line 1 minus line 2)	209,817,817	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	212,105,999	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,288,182	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	398,171	6.00
7.00	Income from investments	1,063,934	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	115,424	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	4,992	13.00
14.00	Revenue from meals sold to employees and guests	797,620	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	1,675,431	17.00
18.00	Revenue from sale of medical records and abstracts	96,963	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	64,307	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	190,545	22.00
23.00	Governmental appropriations	622,500	23.00
24.00	CHANGE IN NET EQUITY OF AFFILIATES	5,953,079	24.00
24.01	DAYCARE REVENUE	493,995	24.01
24.02	EHR REVENUE	215,297	24.02
24.03	MISCELLANEOUS INCOME	281,883	24.03
24.04	INTERCOMPANY PY RENT REVERSAL	961,719	24.04
25.00	Total other income (sum of lines 6-24)	12,935,860	25.00
26.00	Total (line 5 plus line 25)	10,647,678	26.00
27.00	CHANGE IN NET EQUITY OF INVESTEES	369,390	27.00
27.01	INTEREST EXPENSE	605,756	27.01
27.02	LOSS ON SALE OF ASSET	120,224	27.02
27.03	PROVISION FOR INCOME TAXES	157,038	27.03
27.04	DONATION EXPENSES	483,454	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	1,735,862	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,911,816	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet H
		HHA CCN: 14-7562		Date/Time Prepared: 9/26/2017 11:01 am
			Home Health Agency I	PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	198,846	0	17,828	0	114,969	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	627,313	0	0	0	627,313	6.00
7.00	Physical Therapy	154,263	0	0	24,069	178,332	7.00
8.00	Occupational Therapy	0	0	0	1,335	1,335	8.00
9.00	Speech Pathology	3,895	0	0	0	3,895	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	24,769	0	0	0	24,769	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,009,086	0	17,828	25,404	114,969	24.00
	Reclassification		Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-38,491	293,152	-1,107	292,045		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	627,313	0	627,313		6.00
7.00	Physical Therapy	0	178,332	0	178,332		7.00
8.00	Occupational Therapy	0	1,335	0	1,335		8.00
9.00	Speech Pathology	0	3,895	0	3,895		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	24,769	0	24,769		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Tel emedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-38,491	1,128,796	-1,107	1,127,689		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 14-0043 HHA CCN: 14-7562		Period: From 05/01/2016 To 04/30/2017		Worksheet H-1 Part I Date/Time Prepared: 9/26/2017 11:01 am	
				Home Health Agency I		PPS	
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	292,045	0	0	0	292,045	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	627,313	0	0	0	627,313	6.00
7.00	Physical Therapy	178,332	0	0	0	178,332	7.00
8.00	Occupational Therapy	1,335	0	0	0	1,335	8.00
9.00	Speech Pathology	3,895	0	0	0	3,895	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	24,769	0	0	0	24,769	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,127,689	0	0	0	1,127,689	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	292,045					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	219,237	846,550				6.00
7.00	Physical Therapy	62,324	240,656				7.00
8.00	Occupational Therapy	467	1,802				8.00
9.00	Speech Pathology	1,361	5,256				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	8,656	33,425				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		1,127,689				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 14-0043 HHA CCN: 14-7562		Period: From 05/01/2016 To 04/30/2017		Worksheet H-1 Part II Date/Time Prepared: 9/26/2017 11:01 am	
				Home Health Agency I		PPS	
	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-292,045	835,644
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	627,313
7.00	Physical Therapy	0	0	0	0	0	178,332
8.00	Occupational Therapy	0	0	0	0	0	1,335
9.00	Speech Pathology	0	0	0	0	0	3,895
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	24,769
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-292,045	835,644
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		292,045
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.349485

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0043

Period: From 05/01/2016

Worksheet H-2

HHA CCN: 14-7562

To 04/30/2017

Part I
Date/Time Prepared:
9/26/2017 11:01 am

Home Health
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	22,549	32,588	94,672	149,809	33,977	1.00
2.00 Skilled Nursing Care	846,550	0	0	298,667	1,145,217	259,738	2.00
3.00 Physical Therapy	240,656	0	0	73,446	314,102	71,239	3.00
4.00 Occupational Therapy	1,802	0	0	0	1,802	409	4.00
5.00 Speech Pathology	5,256	0	0	1,854	7,110	1,613	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	33,425	0	0	11,793	45,218	10,256	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	1,127,689	22,549	32,588	480,432	1,663,258	377,232	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	28,763	0	17,508	0	2,038	39,341	1.00
2.00 Skilled Nursing Care	0	0	0	0	15,591	0	2.00
3.00 Physical Therapy	0	0	0	0	4,285	0	3.00
4.00 Occupational Therapy	0	0	0	0	30	0	4.00
5.00 Speech Pathology	0	0	0	0	104	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	610	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	28,763	0	17,508	0	22,658	39,341	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0043

Period: From 05/01/2016

Worksheet H-2

HHA CCN: 14-7562

To 04/30/2017

Part I Date/Time Prepared: 9/26/2017 11:01 am

Home Health Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	99	0	10,396	281,931	0	281,931	1.00
2.00	Skilled Nursing Care	0	0	0	1,420,546	0	1,420,546	2.00
3.00	Physical Therapy	0	0	0	389,626	0	389,626	3.00
4.00	Occupational Therapy	0	0	0	2,241	0	2,241	4.00
5.00	Speech Pathology	0	0	0	8,827	0	8,827	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	56,084	0	56,084	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telmedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	99	0	10,396	2,159,255	0	2,159,255	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	213,332	1,633,878					2.00
3.00	Physical Therapy	58,513	448,139					3.00
4.00	Occupational Therapy	337	2,578					4.00
5.00	Speech Pathology	1,326	10,153					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	8,423	64,507					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telmedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	281,931	2,159,255					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.150177						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 14-0043 HHA CCN: 14-7562	Period: From 05/01/2016 To 04/30/2017	Worksheet H-2 Part II Date/Time Prepared: 9/26/2017 11:01 am
			Home Health Agency I	PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	2,320	32,214	198,846	0	149,809	2,320	1.00
2.00 Skilled Nursing Care	0	0	627,313	0	1,145,217	0	2.00
3.00 Physical Therapy	0	0	154,263	0	314,102	0	3.00
4.00 Occupational Therapy	0	0	0	0	1,802	0	4.00
5.00 Speech Pathology	0	0	3,895	0	7,110	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	24,769	0	45,218	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	2,320	32,214	1,009,086		1,663,258	2,320	20.00
21.00 Total cost to be allocated	22,549	32,588	480,432		377,232	28,763	21.00
22.00 Unit cost multiplier	9.719397	1.011610	0.476106		0.226803	12.397845	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATIVE (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	2,320	0	137	31,678	1,415	1.00
2.00 Skilled Nursing Care	0	0	0	1,048	0	0	2.00
3.00 Physical Therapy	0	0	0	288	0	0	3.00
4.00 Occupational Therapy	0	0	0	2	0	0	4.00
5.00 Speech Pathology	0	0	0	7	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	41	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	2,320	0	1,523	31,678	1,415	20.00
21.00 Total cost to be allocated	0	17,508	0	22,658	39,341	99	21.00
22.00 Unit cost multiplier	0.000000	7.546552	0.000000	14.877216	1.241903	0.069965	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 14-0043 HHA CCN: 14-7562	Period: From 05/01/2016 To 04/30/2017	Worksheet H-2 Part II Date/Time Prepared: 9/26/2017 11:01 am PPS
		Home Health Agency I	

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	15.00	16.00		
1.00 Administrative and General	0	1,344,420		1.00
2.00 Skilled Nursing Care	0	0		2.00
3.00 Physical Therapy	0	0		3.00
4.00 Occupational Therapy	0	0		4.00
5.00 Speech Pathology	0	0		5.00
6.00 Medical Social Services	0	0		6.00
7.00 Home Health Aide	0	0		7.00
8.00 Supplies (see instructions)	0	0		8.00
9.00 Drugs	0	0		9.00
10.00 DME	0	0		10.00
11.00 Home Dialysis Aide Services	0	0		11.00
12.00 Respiratory Therapy	0	0		12.00
13.00 Private Duty Nursing	0	0		13.00
14.00 Clinic	0	0		14.00
15.00 Health Promotion Activities	0	0		15.00
16.00 Day Care Program	0	0		16.00
17.00 Home Delivered Meals Program	0	0		17.00
18.00 Homemaker Service	0	0		18.00
19.00 All Others (specify)	0	0		19.00
19.50 Telemedicine	0	0		19.50
20.00 Total (sum of lines 1-19)	0	1,344,420		20.00
21.00 Total cost to be allocated	0	10,396		21.00
22.00 Unit cost multiplier	0.000000	0.007733		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet H-3 Part I Date/Time Prepared: 9/26/2017 11:01 am
		HHA CCN: 14-7562		

		Title XVIII		Home Health Agency I	PPS	
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,633,878		1,633,878	4,150	393.71	1.00
2.00	Physical Therapy	3.00	448,139	0	448,139	1,788	250.64	2.00
3.00	Occupational Therapy	4.00	2,578	0	2,578	22	117.18	3.00
4.00	Speech Pathology	5.00	10,153	0	10,153	54	188.02	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	64,507		64,507	345	186.98	6.00
7.00	Total (sum of lines 1-6)		2,159,255	0	2,159,255	6,359		7.00

Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,456		8.00
9.00	Physical Therapy		99914	0	758		9.00
10.00	Occupational Therapy		99914	0	11		10.00
11.00	Speech Pathology		99914	0	29		11.00
12.00	Medical Social Services		99914	0	0		12.00
13.00	Home Health Aide		99914	0	223		13.00
14.00	Total (sum of lines 8-13)			0	2,477		14.00

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

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	9,880	9,880	11,932	0.828025	15.00
16.00	Cost of Drugs	9.00	0	279	279	628	0.444268	16.00

Cost Center Description		Program Visits		Cost of Services			
		Part A	Part B	Part A	Part B		
			Not Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,456		0	573,242	1.00
2.00	Physical Therapy	0	758		0	189,985	2.00
3.00	Occupational Therapy	0	11		0	1,289	3.00
4.00	Speech Pathology	0	29		0	5,453	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	223		0	41,697	6.00
7.00	Total (sum of lines 1-6)	0	2,477		0	811,666	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 14-0043 HHA CCN: 14-7562	Period: From 05/01/2016 To 04/30/2017	Worksheet H-3 Part I Date/Time Prepared: 9/26/2017 11:01 am
			Title XVIII	Home Health Agency I	PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

Cost Center Description	Program Covered Charges			Cost of Services	Part A	Part B		
	Part A	Part B				Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00		

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	10,331	0	0	8,554	0	15.00
16.00	Cost of Drugs		628	0		279	0	16.00

Cost Center Description		Total Program Cost (sum of cols. 9-10)
		12.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation			
1.00	Skilled Nursing Care	573,242	1.00
2.00	Physical Therapy	189,985	2.00
3.00	Occupational Therapy	1,289	3.00
4.00	Speech Pathology	5,453	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	41,697	6.00
7.00	Total (sum of lines 1-6)	811,666	7.00

Cost Center Description		
		12.00

Limitation Cost Computation			
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 14-0043 HHA CCN: 14-7562	Period: From 05/01/2016 To 04/30/2017	Worksheet H-3 Part II Date/Time Prepared: 9/26/2017 11:01 am
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.548959	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.600513	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.476228	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.828036	11,932	9,880	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.443479	628	279	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0043 HHA CCN: 14-7562	Period: From 05/01/2016 To 04/30/2017	Worksheet H-4 Part I-II Date/Time Prepared: 9/26/2017 11:01 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	279	0
2.00	Total charges	0	628	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	628	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	349	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	279
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	497,435
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0
13.00	Total PPS Reimbursement - LUPA Episodes		0	22,443
14.00	Total PPS Reimbursement - PEP Episodes		0	6,755
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	526,912
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	526,912
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	526,912
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	526,912
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	526,912
31.01	Sequestration adjustment (see instructions)		0	10,538
32.00	Interim payments (see instructions)		0	516,592
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-218
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet H-5
	HHA CCN: 14-7562	Home Health Agency I	Date/Time Prepared: 9/26/2017 11:01 am PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		516,592	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		516,592	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		218	6.02
7.00	Total Medicare program liability (see instructions)		0		516,374	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0043	Period: From 05/01/2016 To 04/30/2017	Worksheet L Parts I-III Date/Time Prepared: 9/26/2017 11:01 am
		Title XVII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,216,523	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		29,452	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		36.53	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,245,975	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00