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: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/24/2017 1:24 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/24/2017 Time: 1:24 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PASSAVANT AREA HOSPITAL (14-0058) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-142,168	-33,531	378,790	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
7.00	SKILLED NURSING FACILITY	0	0	-114		0	7.00
200.00	Total	0	-142,168	-33,645	378,790	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 3:46 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1600 WEST WALNUT	PO Box:			1.00
2.00	City: JACKSONVILLE	State: IL	Zip Code: 62650-1185	County: MORGAN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PASSAVANT AREA HOSPITAL	140058	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									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	PASSAVANT AREA HOSPITAL	145951	99914		10/31/1997	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,108	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 3:46 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	10/01/2015	09/30/2016	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 3:46 pm

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 3:46 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		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	Y	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)			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. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	518,500	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2017 3:46 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H058	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: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
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)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 3:46 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	09/30/2016	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. I, 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	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2017 3:46 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/10/2017	Y	02/10/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2017 3:46 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.	PATRICIA		RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/23/2017 3:46 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2017 3:46 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	94	31,484	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)		94	31,484	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,294	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)		103	34,778	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	44.00	15	5,490		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		118				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: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2017 3:46 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,749	1,444	8,345			1.00
2.00	HMO and other (see instructions)	658	27				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,749	1,444	8,345			7.00
8.00	INTENSIVE CARE UNIT	757	221	1,301			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		416	722			13.00
14.00	Total (see instructions)	5,506	2,081	10,368	0.00	654.74	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	3,175	0	4,377	0.00	16.91	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	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	671.65	27.00
28.00	Observation Bed Days		154	638			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			305			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	118			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: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2017 3:46 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,452	595	3,192	1.00
2.00	HMO and other (see instructions)			183	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	1,452	595	3,192	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	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: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2017 3:46 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	37,058,536	0	37,058,536	1,397,034.59	26.53	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		5,750	0	5,750	46.00	125.00	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		340,376	0	340,376	2,723.01	125.00	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	896,795	0	896,795	35,163.65	25.50	9.00
10.00	Excluded area salaries (see instructions)		204,548	0	204,548	2,309.29	88.58	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		86,903	0	86,903	2,140.50	40.60	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		175,421	0	175,421	1,736.75	101.01	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		617,479	0	617,479	2,080.00	296.86	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)		15,667,472	0	15,667,472			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		447,880	0	447,880			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		1,116	0	1,116			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		66,056	0	66,056			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 orgainzation 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
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	400,446	0	400,446	12,933.21	30.96	26.00
27.00	Administrative & General	5.00	6,700,313	0	6,700,313	376,867.90	17.78	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2017 3:46 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		96,995	0	96,995	666.15	145.61	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,049,511	0	1,049,511	39,028.12	26.89	30.00
31.00	Laundry & Linen Service	8.00	227,969	0	227,969	17,036.67	13.38	31.00
32.00	Housekeeping	9.00	914,426	0	914,426	74,385.63	12.29	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,167,178	-755,047	412,131	27,761.01	14.85	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	755,047	755,047	50,859.81	14.85	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	735,035	0	735,035	18,253.23	40.27	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	770,994	0	770,994	21,110.77	36.52	40.00
41.00	Medical Records & Medical Records Library	16.00	716,302	0	716,302	31,744.76	22.56	41.00
42.00	Social Service	17.00	150,073	0	150,073	4,259.78	35.23	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 2/23/2017 3:46 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		36,815,155	0	36,815,155	1,394,977.73	26.39	1.00
2.00	Excluded area salaries (see instructions)		1,101,343	0	1,101,343	37,472.94	29.39	2.00
3.00	Subtotal salaries (line 1 minus line 2)		35,713,812	0	35,713,812	1,357,504.79	26.31	3.00
4.00	Subtotal other wages & related costs (see inst.)		879,803	0	879,803	5,957.25	147.69	4.00
5.00	Subtotal wage-related costs (see inst.)		15,668,588	0	15,668,588	0.00	43.87	5.00
6.00	Total (sum of lines 3 thru 5)		52,262,203	0	52,262,203	1,363,462.04	38.33	6.00
7.00	Total overhead cost (see instructions)		12,929,242	0	12,929,242	674,907.04	19.16	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 2/23/2017 3:46 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,765,779	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	10,488,902	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)	33,160	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)	176,504	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	886,441	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,749,301	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	45,191	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	37,245	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	16,182,523	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: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 2/23/2017 3:46 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	183,898	0	1.00
2.00	Hospital	183,898	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet S-7 Date/Time Prepared: 2/23/2017 3:46 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	3	0	3	12.00
13.00		RUB	53	0	53	13.00
14.00		RUA	14	0	14	14.00
15.00		RVC	74	0	74	15.00
16.00		RVB	152	0	152	16.00
17.00		RVA	920	0	920	17.00
18.00		RHC	97	0	97	18.00
19.00		RHB	351	0	351	19.00
20.00		RHA	676	0	676	20.00
21.00		RMC	23	0	23	21.00
22.00		RMB	91	0	91	22.00
23.00		RMA	139	0	139	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	4	0	4	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	45	0	45	31.00
32.00		HD1	9	0	9	32.00
33.00		HC2	61	0	61	33.00
34.00		HC1	9	0	9	34.00
35.00		HB2	24	0	24	35.00
36.00		HB1	46	0	46	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	14	0	14	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	16	0	16	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	7	0	7	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	6	0	6	46.00
47.00		CD2	7	0	7	47.00
48.00		CD1	14	0	14	48.00
49.00		CC2	4	0	4	49.00
50.00		CC1	43	0	43	50.00
51.00		CB2	7	0	7	51.00
52.00		CB1	137	0	137	52.00
53.00		CA2	21	0	21	53.00
54.00		CA1	75	0	75	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	3	0	3	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-7 | Date/Time Prepared: 2/23/2017 3:46 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	9	0	9	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	21	0	21	199.00
200.00	TOTAL		3,175	0	3,175	200.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	896,795	13.96	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	6,426,328			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/23/2017 3:46 pm

		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)	0.241085	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,918,863	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	6,243,586	5.00
6.00	Medicaid charges	60,426,514	6.00
7.00	Medicaid cost (line 1 times line 6)	14,567,926	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)	2,405,477	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	190,678	9.00
10.00	Stand-alone CHIP charges	929,686	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	224,133	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	33,455	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)	2,438,932	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)	1,465,282	0	1,465,282	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	353,258	0	353,258	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	353,258	0	353,258	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?		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)	4,090,295	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	583,005	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,507,290	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	845,555	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,198,813	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,637,745	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,291,456	1,291,456	957,245	2,248,701	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,682,051	1,682,051	69,327	1,751,378	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	400,446	16,559,241	16,959,687	0	16,959,687	4.00
5.01	00540	NONPATIENT TELEPHONES	0	56,198	56,198	0	56,198	5.01
5.02	00550	DATA PROCESSING	921,036	1,895,804	2,816,840	0	2,816,840	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	309,034	174,841	483,875	0	483,875	5.03
5.04	00570	ADMITTING	709,594	26,150	735,744	0	735,744	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	807,689	526,950	1,334,639	0	1,334,639	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	3,952,960	6,582,375	10,535,335	0	10,535,335	5.06
7.00	00700	OPERATION OF PLANT	1,049,511	2,193,384	3,242,895	-135,617	3,107,278	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	227,969	93,378	321,347	0	321,347	8.00
9.00	00900	HOUSEKEEPING	914,426	186,874	1,101,300	0	1,101,300	9.00
10.00	01000	DIETARY	1,167,178	1,069,067	2,236,245	-1,447,017	789,228	10.00
11.00	01100	CAFETERIA	0	0	0	1,447,017	1,447,017	11.00
13.00	01300	NURSING ADMINISTRATION	735,035	52,137	787,172	0	787,172	13.00
15.00	01500	PHARMACY	770,994	3,670,584	4,441,578	-3,173,676	1,267,902	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	716,302	80,259	796,561	0	796,561	16.00
17.00	01700	SOCIAL SERVICE	150,073	693	150,766	0	150,766	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,928	0	1,928	0	1,928	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,347,903	1,171,746	5,519,649	-1,564	5,518,085	30.00
31.00	03100	INTENSIVE CARE UNIT	1,153,749	53,374	1,207,123	-296	1,206,827	31.00
43.00	04300	NURSERY	349,329	49,518	398,847	0	398,847	43.00
44.00	04400	SKILLED NURSING FACILITY	896,795	54,404	951,199	-15	951,184	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,073,662	5,454,260	9,527,922	-2,276,929	7,250,993	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,332	12,380	99,712	0	99,712	52.00
53.00	05300	ANESTHESIOLOGY	254,403	387,727	642,130	0	642,130	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,469,331	1,343,694	3,813,025	0	3,813,025	54.00
60.00	06000	LABORATORY	1,895,498	2,226,038	4,121,536	0	4,121,536	60.00
65.00	06500	RESPIRATORY THERAPY	899,768	287,787	1,187,555	0	1,187,555	65.00
66.00	06600	PHYSICAL THERAPY	2,581,860	281,830	2,863,690	0	2,863,690	66.00
68.00	06800	SPEECH PATHOLOGY	199,697	6,159	205,856	0	205,856	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,340	788	7,128	0	7,128	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,877	348,169	485,046	0	485,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,276,929	2,276,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,175,551	3,175,551	73.00
74.00	07400	RENAL DIALYSIS	0	17,630	17,630	0	17,630	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	138,826	18,146	156,972	0	156,972	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	95,958	41,270	137,228	0	137,228	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	621,231	440,439	1,061,670	0	1,061,670	90.00
91.00	09100	EMERGENCY	3,811,254	2,743,666	6,554,920	0	6,554,920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,026,572	1,026,572	-1,026,572	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,853,988	52,107,039	88,961,027	-135,617	88,825,410	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	204,548	48,354	252,902	135,617	388,519	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	37,058,536	52,155,393	89,213,929	0	89,213,929	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,222,593	3,471,294		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,680,729	3,432,107		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,092,314	12,867,373		4.00
5.01	00540	NONPATIENT TELEPHONES	-8,858	47,340		5.01
5.02	00550	DATA PROCESSING	0	2,816,840		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	483,875		5.03
5.04	00570	ADMITTING	0	735,744		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,334,639		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-2,664,486	7,870,849		5.06
7.00	00700	OPERATION OF PLANT	-17,241	3,090,037		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	321,347		8.00
9.00	00900	HOUSEKEEPING	0	1,101,300		9.00
10.00	01000	DIETARY	-57,652	731,576		10.00
11.00	01100	CAFETERIA	-420,336	1,026,681		11.00
13.00	01300	NURSING ADMINISTRATION	-15,080	772,092		13.00
15.00	01500	PHARMACY	0	1,267,902		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-27,184	769,377		16.00
17.00	01700	SOCIAL SERVICE	0	150,766		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,928	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-873,324	4,644,761		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,206,827		31.00
43.00	04300	NURSERY	0	398,847		43.00
44.00	04400	SKILLED NURSING FACILITY	0	951,184		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-12,108	7,238,885		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	99,712		52.00
53.00	05300	ANESTHESIOLOGY	0	642,130		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,106	3,811,919		54.00
60.00	06000	LABORATORY	-75,000	4,046,536		60.00
65.00	06500	RESPIRATORY THERAPY	-740	1,186,815		65.00
66.00	06600	PHYSICAL THERAPY	-134,202	2,729,488		66.00
68.00	06800	SPEECH PATHOLOGY	0	205,856		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,128		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	485,046		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,276,929		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,175,551		73.00
74.00	07400	RENAL DIALYSIS	-1,558	16,072		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	156,972		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-1,040	136,188		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-389,837	671,833		90.00
91.00	09100	EMERGENCY	-1,836,959	4,717,961		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,727,631	81,097,779		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	388,519		192.00
192.01	19201	RENTED SPACE	0	0		192.01
194.00	07950	FUND DEVELOPMENT	0	0		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-7,727,631	81,486,298		200.00

RECLASSIFICATIONS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/23/2017 3:46 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	755,047	691,970	1.00
	0		755,047	691,970	
	B - RECLASS SPOILED DRUGS EXPENSE				
1.00	PHARMACY	15.00	0	1,875	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	1,875	
	C - RECLASS CHARGEABLE DRUG COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,175,551	1.00
	0		0	3,175,551	
	D - RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	957,245	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	69,327	2.00
	0		0	1,026,572	
	G - RECLASS REAL ESTATE TAXES				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	135,617	1.00
	0		0	135,617	
	H - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,276,929	1.00
	0		0	2,276,929	
500.00	Grand Total: Increases		755,047	7,308,514	500.00

RECLASSIFICATIONS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/23/2017 3:46 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	755,047	691,970	0		1.00
	0		755,047	691,970			
	B - RECLASS SPOILED DRUGS EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	1,564	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	296	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	15	0		3.00
	0		0	1,875			
	C - RECLASS CHARGEABLE DRUG COSTS						
1.00	PHARMACY	15.00	0	3,175,551	0		1.00
	0		0	3,175,551			
	D - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,026,572	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,026,572			
	G - RECLASS REAL ESTATE TAXES						
1.00	OPERATION OF PLANT	7.00	0	135,617	0		1.00
	0		0	135,617			
	H - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	2,276,929	0		1.00
	0		0	2,276,929			
500.00	Grand Total: Decreases		755,047	7,308,514			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I Date/Time Prepared: 2/23/2017 3:46 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	242,737	0	0	0	0	1.00
2.00	Land Improvements	3,304,654	12,693	0	12,693	0	2.00
3.00	Buildings and Fixtures	40,736,775	1,422,720	0	1,422,720	0	3.00
4.00	Building Improvements	5,121,823	0	0	0	0	4.00
5.00	Fixed Equipment	45,937,446	4,308,751	0	4,308,751	6,105	5.00
6.00	Movable Equipment	38,357,235	3,802,252	0	3,802,252	1,886,914	6.00
7.00	HIT designated Assets	2,466,880	0	0	0	425,061	7.00
8.00	Subtotal (sum of lines 1-7)	136,167,550	9,546,416	0	9,546,416	2,318,080	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	136,167,550	9,546,416	0	9,546,416	2,318,080	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	242,737	0	1.00
2.00	Land Improvements	3,317,347	0	2.00
3.00	Buildings and Fixtures	42,159,495	0	3.00
4.00	Building Improvements	5,121,823	0	4.00
5.00	Fixed Equipment	50,240,092	0	5.00
6.00	Movable Equipment	40,272,573	0	6.00
7.00	HIT designated Assets	2,041,819	0	7.00
8.00	Subtotal (sum of lines 1-7)	143,395,886	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	143,395,886	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2017 3:46 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,291,456	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,682,051	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,973,507	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,291,456		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,682,051		2.00
3.00	Total (sum of lines 1-2)	0	2,973,507		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2017 3:46 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	95,959,671	0	95,959,671	0.699320	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,314,392	1,055,527	41,258,865	0.300680	0	2.00
3.00	Total (sum of lines 1-2)	138,274,063	1,055,527	137,218,536	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,566,640	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,366,589	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,933,229	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	904,654	0	0	0	3,471,294	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,518	0	0	0	3,432,107	2.00
3.00	Total (sum of lines 1-2)	970,172	0	0	0	6,903,401	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/23/2017 3:46 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-52,591	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-3,809	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-8,858	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-17,241	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,462,453			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	1,978,737			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-420,336	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-27,184	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	-10,101	DIETARY	10.00	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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	HEALTH EDUCATION	B	-135	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/23/2017 3:46 pm

	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	
33.01	MISC INCOME	B	-476,257	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.01
33.02	WEE CARE	B	-657	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.02
33.03	DOORBELL DINNERS	B	-47,551	DIETARY	10.00	0	33.03
33.04	CHILDBIRTH PREP	B	-105	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.04
33.05	MISCELLANEOUS NURSE ADMIN INCOME	B	-15,080	NURSING ADMINISTRATION	13.00	0	33.05
33.06	MISCELLANEOUS PT INCOME	B	-133,243	PHYSICAL THERAPY	66.00	0	33.06
33.07	MISCELLANEOUS ER INCOME	B	-12,090	EMERGENCY	91.00	0	33.07
33.08	MISCELLANEOUS WOC CONTRACTUAL INCOME	B	-13,331	CLINIC	90.00	0	33.08
33.09	INDUSTRIAL REHAB CABLE EXPENSE	A	-959	PHYSICAL THERAPY	66.00	0	33.09
33.10	HYPERBARICS CABLE EXPENSE	A	-1,040	HYPERBARIC OXYGEN THERAPY	76.98	0	33.10
33.11			0		0.00	0	33.11
33.12	INTERMEDIARY DEPRECIATION ADJUSTMENT	A	30,552	CAP REL COSTS-BLDG & FIXT	1.00	9	33.12
33.13			0		0.00	0	33.13
33.14	SELF INSURANCE	A	-3,848,994	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	PHYSICIAN RECRUITMENT	A	-92,031	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.15
33.16	PARAMEDIC SALARY EXPENSE	A	-14,662	EMERGENCY	91.00	0	33.16
33.17	PARAMEDIC EMPLOYEE BENEFIT EXPENSE	A	-4,951	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	PARAMEDIC OTHER EXPENSE	A	-842	EMERGENCY	91.00	0	33.18
33.19	PARAMEDIC CRC EXPENSE	A	-485	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	INCOME TAX EXPENSE	A	-7,926	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.20
33.21	LOBBYING EXPENSE	A	-31,672	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.21
33.22	COMMUNITY RELATIONS SALARY EXPENSE	A	-254,353	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.22
33.23	COMMUNITY RELATIONS BENEFITS EXPENSE	A	-85,895	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	COMMUNITY RELATIONS OTHER EXPENSE	A	-263,143	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.24
33.25	ALCOHOL EXPENSE	A	-1,149	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.25
33.26	TRUST ACCOUNT FEES	A	189,556	OTHER ADMINISTRATIVE AND GENERAL	5.06	9	33.26
33.27	LIFE LINE EXPENSES	A	-71,704	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.27
33.28	PROVIDER TAX	A	-2,202,359	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.28
33.30			0		0.00	0	33.30
33.31			0		0.00	0	33.31
33.32	EDUCATION INCOME - AHA	B	-15,876	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.32
33.33			0		0.00	0	33.33
33.34	EMPLOYEE SERVICES INCOME	B	-100	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.34
33.35			0		0.00	0	33.35
33.36	PHYSICIAN LOAN FORGIVENESS	A	-74,371	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.36
33.37			0		0.00	0	33.37
33.38	REVALUED ASSETS DEPRECIATION ADJUSTM	A	1,228,144	CAP REL COSTS-BLDG & FIXT	1.00	9	33.38
33.39	REVALUED ASSETS DEPRECIATION ADJUSTM	A	1,673,608	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.39
33.40			0		0.00	0	33.40
33.41	EXECUTIVE OFFICE	A	-292	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.41
33.42	COMMUNITY BENFIT SALARY EXPENSE	A	-27,860	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.42
33.43	COMMUNITY BENFIT BENEFITS EXPENSE	A	-9,408	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.43
33.44	COMMUNITY BENFIT OTHER EXPENSE	A	-115,206	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	CRNA SALARIES	A	-1,928	NONPHYSICIAN ANESTHETISTS	19.00	0	33.45

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/23/2017 3:46 pm

	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	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,727,631				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-1 Date/Time Prepared: 2/23/2017 3:46 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAP BLDG HO	16,488	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAP MME HO MME CAP	11,415	0	2.00
3.00	5.06	OTHER ADMINISTRATIVE AND GEN	HO INTEREST	17,886	0	3.00
4.00	5.06	OTHER ADMINISTRATIVE AND GEN	A&G HO MANAGEMENT	2,810,198	877,250	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,855,987	877,250	5.00

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

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

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	C		0.00	PPA	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2017 3:46 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	16,488	9		1.00
2.00	11,415	9		2.00
3.00	17,886	0		3.00
4.00	1,932,948	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	1,978,737			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	PHYSICIAN ORG		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2017 3:46 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	1,411,073	1,300,852	110,221	211,500	967	1.00
2.00	30.00	ADULTS & PEDIATRICS	873,426	873,276	150	211,500	1	2.00
3.00	50.00	OPERATING ROOM	17,557	11,807	5,750	246,400	46	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	7,250	0	7,250	271,900	47	4.00
5.00	60.00	LABORATORY	75,000	75,000	0	260,300	0	5.00
6.00	65.00	RESPIRATORY THERAPY	1,350	0	1,350	211,500	6	6.00
7.00	74.00	RENAL DIALYSIS	2,778	378	2,400	211,500	12	7.00
8.00	90.00	CLINIC	376,506	376,506	0	211,500	0	8.00
9.00	91.00	EMERGENCY	1,861,315	1,809,365	51,950	211,500	705	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,626,255	4,447,184	179,071		1,784	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	5.06	OTHER ADMINISTRATIVE AND GENERAL	98,327	4,916	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	102	5	0	0	0	2.00
3.00	50.00	OPERATING ROOM	5,449	272	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	6,144	307	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	610	31	0	0	0	6.00
7.00	74.00	RENAL DIALYSIS	1,220	61	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	71,686	3,584	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			183,538	9,176	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	98,327	11,894	1,312,746		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	102	48	873,324		2.00
3.00	50.00	OPERATING ROOM	0	5,449	301	12,108		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	6,144	1,106	1,106		4.00
5.00	60.00	LABORATORY	0	0	0	75,000		5.00
6.00	65.00	RESPIRATORY THERAPY	0	610	740	740		6.00
7.00	74.00	RENAL DIALYSIS	0	1,220	1,180	1,558		7.00
8.00	90.00	CLINIC	0	0	0	376,506		8.00
9.00	91.00	EMERGENCY	0	71,686	0	1,809,365		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	183,538	15,269	4,462,453		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,471,294	3,471,294				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,432,107		3,432,107			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,867,373	85,778	51,376	13,004,527		4.00
5.01	00540	NONPATIENT TELEPHONES	47,340	10,631	0	0	57,971	5.01
5.02	00550	DATA PROCESSING	2,816,840	38,062	466,659	329,172	3,410	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	483,875	98,388	0	110,447	647	5.03
5.04	00570	ADMITTING	735,744	13,099	758	253,604	1,823	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,334,639	25,555	0	288,662	1,176	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	7,870,849	269,841	62,316	1,321,857	14,049	5.06
7.00	00700	OPERATION OF PLANT	3,090,037	430,856	66,931	375,088	2,411	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	321,347	72,975	10,809	81,475	235	8.00
9.00	00900	HOUSEKEEPING	1,101,300	137,903	23,564	326,809	353	9.00
10.00	01000	DIETARY	731,576	78,001	31,842	147,293	1,235	10.00
11.00	01100	CAFETERIA	1,026,681	61,084	0	269,849	0	11.00
13.00	01300	NURSING ADMINISTRATION	772,092	17,418	4,682	262,696	0	13.00
15.00	01500	PHARMACY	1,267,902	33,653	6,307	275,548	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	769,377	46,263	0	256,001	1,117	16.00
17.00	01700	SOCIAL SERVICE	150,766	0	0	53,635	118	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,644,761	453,991	143,268	1,553,923	5,409	30.00
31.00	03100	INTENSIVE CARE UNIT	1,206,827	69,440	43,296	412,342	941	31.00
43.00	04300	NURSERY	398,847	9,988	0	124,848	412	43.00
44.00	04400	SKILLED NURSING FACILITY	951,184	86,832	18,026	320,508	882	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,238,885	229,401	881,935	1,455,898	2,058	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,712	20,503	0	31,212	118	52.00
53.00	05300	ANESTHESIOLOGY	642,130	13,356	29,488	90,922	1,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,811,919	168,496	926,672	882,522	3,234	54.00
60.00	06000	LABORATORY	4,046,536	101,524	118,850	677,438	2,293	60.00
65.00	06500	RESPIRATORY THERAPY	1,186,815	59,182	90,207	321,571	1,176	65.00
66.00	06600	PHYSICAL THERAPY	2,729,488	121,089	24,477	922,739	882	66.00
68.00	06800	SPEECH PATHOLOGY	205,856	4,023	654	71,370	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,128	0	0	2,266	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	485,046	70,057	72,414	48,919	235	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,276,929	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,175,551	3,149	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,072	0	4,161	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	156,972	38,152	9,220	49,615	235	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	136,188	16,351	11,077	34,295	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	671,833	33,871	21,704	222,024	1,587	90.00
91.00	09100	EMERGENCY	4,717,961	266,627	176,000	1,356,875	4,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	81,097,779	3,185,539	3,296,693	12,931,423	52,210	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,557	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	388,519	1,620	135,414	73,104	1,293	192.00
192.01	19201	RENTED SPACE	0	267,578	0	0	4,468	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	81,486,298	3,471,294	3,432,107	13,004,527	57,971	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,654,143					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	40,574	733,931				5.03
5.04	00570	ADMITTING	284,267	11,211	1,300,506			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	243,568	46,360	0	1,939,960		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	284,267	108,230	0	0	9,931,409	5.06
7.00	00700	OPERATION OF PLANT	0	55,032	0	0	4,020,355	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,450	0	0	536,291	8.00
9.00	00900	HOUSEKEEPING	0	94,959	0	0	1,684,888	9.00
10.00	01000	DIETARY	324,841	39,267	0	0	1,354,055	10.00
11.00	01100	CAFETERIA	0	80,572	0	0	1,438,186	11.00
13.00	01300	NURSING ADMINISTRATION	405,985	4,484	0	0	1,467,357	13.00
15.00	01500	PHARMACY	81,147	11,034	0	0	1,675,591	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	324,841	0	0	0	1,397,599	16.00
17.00	01700	SOCIAL SERVICE	40,574	10,023	0	0	255,116	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	365,414	17,354	67,989	101,433	7,353,542	30.00
31.00	03100	INTENSIVE CARE UNIT	243,568	2,557	23,836	35,560	2,038,367	31.00
43.00	04300	NURSERY	0	611	4,698	7,010	546,414	43.00
44.00	04400	SKILLED NURSING FACILITY	81,147	3,270	19,316	28,817	1,509,982	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,574	57,396	221,260	330,099	10,457,506	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	153	4,903	7,315	163,916	52.00
53.00	05300	ANESTHESIOLOGY	0	2,926	33,677	50,243	863,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,847	16,389	368,604	549,653	6,849,336	54.00
60.00	06000	LABORATORY	202,994	52,276	148,486	221,526	5,571,923	60.00
65.00	06500	RESPIRATORY THERAPY	121,847	24,158	81,188	121,124	2,007,268	65.00
66.00	06600	PHYSICAL THERAPY	121,847	7,547	66,486	99,190	4,093,745	66.00
68.00	06800	SPEECH PATHOLOGY	0	893	3,105	4,632	290,533	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	82	447	667	10,590	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,504	24,080	35,926	739,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	25,867	38,592	2,341,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	95,884	143,049	3,417,633	73.00
74.00	07400	RENAL DIALYSIS	0	0	232	346	20,811	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,915	2,207	3,292	261,608	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	510	3,049	4,549	206,019	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,717	8,699	12,978	979,413	90.00
91.00	09100	EMERGENCY	121,847	24,047	96,493	143,959	6,908,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,451,149	731,927	1,300,506	1,939,960	80,392,747	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	16,557	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	202,994	2,004	0	0	804,948	192.00
192.01	19201	RENTED SPACE	0	0	0	0	272,046	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,654,143	733,931	1,300,506	1,939,960	81,486,298	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	9,931,409					5.06
7.00	00700	OPERATION OF PLANT	558,001	4,578,356				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,434	133,691	744,416			8.00
9.00	00900	HOUSEKEEPING	233,852	252,639	9,099	2,180,478		9.00
10.00	01000	DIETARY	187,935	142,898	4,053	0	1,688,941	10.00
11.00	01100	CAFETERIA	199,612	111,907	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	203,660	31,910	0	509,318	0	13.00
15.00	01500	PHARMACY	232,562	61,653	0	45,577	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	193,978	84,755	0	26,939	0	16.00
17.00	01700	SOCIAL SERVICE	35,409	0	0	4,317	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,020,628	831,722	151,623	182,474	1,106,153	30.00
31.00	03100	INTENSIVE CARE UNIT	282,913	127,214	19,360	45,577	99,764	31.00
43.00	04300	NURSERY	75,839	18,298	4,347	48,607	0	43.00
44.00	04400	SKILLED NURSING FACILITY	209,576	159,077	59,494	86,090	483,024	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,451,458	420,265	246,012	193,931	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,751	37,561	1,087	12,162	0	52.00
53.00	05300	ANESTHESIOLOGY	119,915	24,468	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	950,647	308,687	73,694	84,969	0	54.00
60.00	06000	LABORATORY	773,349	185,994	224	63,094	0	60.00
65.00	06500	RESPIRATORY THERAPY	278,597	108,422	2,209	59,981	0	65.00
66.00	06600	PHYSICAL THERAPY	568,187	221,836	23,669	147,773	0	66.00
68.00	06800	SPEECH PATHOLOGY	40,324	7,371	0	32,626	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,470	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	102,594	128,345	0	30,385	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	324,971	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	474,347	5,770	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,888	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	36,310	69,895	177	23,038	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	28,594	29,955	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	135,937	62,053	0	0	0	90.00
91.00	09100	EMERGENCY	958,893	488,464	143,858	223,818	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,779,631	4,054,850	738,906	1,820,676	1,688,941	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,298	30,332	0	32,917	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	111,722	2,967	5,510	326,885	0	192.00
192.01	19201	RENTED SPACE	37,758	490,207	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,931,409	4,578,356	744,416	2,180,478	1,688,941	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,749,705					11.00
13.00	01300	NURSING ADMINISTRATION	0	2,212,245				13.00
15.00	01500	PHARMACY	49,115	0	2,064,498			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	73,842	0	0	1,777,113		16.00
17.00	01700	SOCIAL SERVICE	9,920	0	0	0	304,762	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	373,371	745,980	702	92,917	172,482	30.00
31.00	03100	INTENSIVE CARE UNIT	78,584	152,003	175	32,575	26,890	31.00
43.00	04300	NURSERY	27,679	60,962	176	6,421	14,923	43.00
44.00	04400	SKILLED NURSING FACILITY	81,826	192,451	9	26,398	90,467	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	179,524	423,401	30,240	302,385	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,920	15,240	44	6,701	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	66,263	46,025	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	192,105	17,218	70,891	503,528	0	54.00
60.00	06000	LABORATORY	198,009	52	1,753	202,928	0	60.00
65.00	06500	RESPIRATORY THERAPY	72,777	12,810	12,636	110,955	0	65.00
66.00	06600	PHYSICAL THERAPY	49,938	0	0	90,863	0	66.00
68.00	06800	SPEECH PATHOLOGY	9,968	0	0	4,243	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	532	0	0	611	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,888	143	1,322	32,910	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,873,008	35,352	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	131,039	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	317	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,871	6,139	0	3,016	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	7,452	0	0	4,167	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	36,921	60,228	1,387	11,889	0	90.00
91.00	09100	EMERGENCY	266,092	507,993	5,834	131,873	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,744,334	2,194,620	2,064,440	1,777,113	304,762	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,371	17,625	58	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,749,705	2,212,245	2,064,498	1,777,113	304,762	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	12,031,594	0	12,031,594		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,903,422	0	2,903,422		31.00
43.00	04300	NURSERY	0	803,666	0	803,666		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,898,394	0	2,898,394		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,704,722	0	13,704,722		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	266,382	0	266,382		52.00
53.00	05300	ANESTHESIOLOGY	0	1,120,648	0	1,120,648		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,051,075	0	9,051,075		54.00
60.00	06000	LABORATORY	0	6,997,326	0	6,997,326		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,665,655	0	2,665,655		65.00
66.00	06600	PHYSICAL THERAPY	0	5,196,011	0	5,196,011		66.00
68.00	06800	SPEECH PATHOLOGY	0	385,065	0	385,065		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,203	0	13,203		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,054,768	0	1,054,768		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,574,719	0	4,574,719		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,028,789	0	4,028,789		73.00
74.00	07400	RENAL DIALYSIS	0	24,016	0	24,016		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	410,054	0	410,054		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	276,187	0	276,187		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,287,828	0	1,287,828		90.00
91.00	09100	EMERGENCY	0	9,635,573	0	9,635,573		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	79,329,097	0	79,329,097		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82,104	0	82,104		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,275,086	0	1,275,086		192.00
192.01	19201	RENTED SPACE	0	800,011	0	800,011		192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	81,486,298	0	81,486,298		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	85,778	51,376	137,154	137,154	4.00
5.01	00540	NONPATIENT TELEPHONES	0	10,631	0	10,631	0	5.01
5.02	00550	DATA PROCESSING	0	38,062	466,659	504,721	3,471	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	98,388	0	98,388	1,165	5.03
5.04	00570	ADMITTING	0	13,099	758	13,857	2,674	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	25,555	0	25,555	3,044	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	847	269,841	62,316	333,004	13,940	5.06
7.00	00700	OPERATION OF PLANT	5,221	430,856	66,931	503,008	3,956	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,975	10,809	83,784	859	8.00
9.00	00900	HOUSEKEEPING	0	137,903	23,564	161,467	3,446	9.00
10.00	01000	DIETARY	0	78,001	31,842	109,843	1,553	10.00
11.00	01100	CAFETERIA	0	61,084	0	61,084	2,846	11.00
13.00	01300	NURSING ADMINISTRATION	0	17,418	4,682	22,100	2,770	13.00
15.00	01500	PHARMACY	3,775	33,653	6,307	43,735	2,906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,263	0	46,263	2,700	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	566	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,229	453,991	143,268	619,488	16,399	30.00
31.00	03100	INTENSIVE CARE UNIT	3,635	69,440	43,296	116,371	4,348	31.00
43.00	04300	NURSERY	0	9,988	0	9,988	1,317	43.00
44.00	04400	SKILLED NURSING FACILITY	12,836	86,832	18,026	117,694	3,380	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	60,261	229,401	881,935	1,171,597	15,354	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	20,503	0	20,503	329	52.00
53.00	05300	ANESTHESIOLOGY	14,318	13,356	29,488	57,162	959	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	168,496	926,672	1,095,168	9,307	54.00
60.00	06000	LABORATORY	866	101,524	118,850	221,240	7,144	60.00
65.00	06500	RESPIRATORY THERAPY	2,736	59,182	90,207	152,125	3,391	65.00
66.00	06600	PHYSICAL THERAPY	0	121,089	24,477	145,566	9,731	66.00
68.00	06800	SPEECH PATHOLOGY	0	4,023	654	4,677	753	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	24	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70,057	72,414	142,471	516	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	3,149	0	3,149	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	4,161	4,161	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	832	38,152	9,220	48,204	523	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	16,351	11,077	27,428	362	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	33,871	21,704	55,575	2,341	90.00
91.00	09100	EMERGENCY	16,017	266,627	176,000	458,644	14,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	143,573	3,185,539	3,296,693	6,625,805	136,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,557	0	16,557	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,620	135,414	137,034	771	192.00
192.01	19201	RENTED SPACE	0	267,578	0	267,578	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	143,573	3,471,294	3,432,107	7,046,974	137,154	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		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
5.01	00540	NONPATIENT TELEPHONES	10,631					5.01
5.02	00550	DATA PROCESSING	625	508,817				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	119	5,650	105,322			5.03
5.04	00570	ADMITTING	334	39,582	1,609	58,056		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	216	33,915	6,653	0	69,383	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	2,577	39,582	15,531	0	0	5.06
7.00	00700	OPERATION OF PLANT	442	0	7,897	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43	0	7,096	0	0	8.00
9.00	00900	HOUSEKEEPING	65	0	13,627	0	0	9.00
10.00	01000	DIETARY	226	45,232	5,635	0	0	10.00
11.00	01100	CAFETERIA	0	0	11,562	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	56,533	644	0	0	13.00
15.00	01500	PHARMACY	0	11,299	1,583	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	205	45,232	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	22	5,650	1,438	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	992	50,882	2,490	3,028	3,630	30.00
31.00	03100	INTENSIVE CARE UNIT	173	33,915	367	1,062	1,273	31.00
43.00	04300	NURSERY	75	0	88	209	251	43.00
44.00	04400	SKILLED NURSING FACILITY	162	11,299	469	860	1,031	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	377	5,650	8,237	9,854	11,813	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22	0	22	218	262	52.00
53.00	05300	ANESTHESIOLOGY	226	0	420	1,500	1,798	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593	16,966	2,352	16,555	19,627	54.00
60.00	06000	LABORATORY	420	28,266	7,502	6,613	7,928	60.00
65.00	06500	RESPIRATORY THERAPY	216	16,966	3,467	3,616	4,335	65.00
66.00	06600	PHYSICAL THERAPY	162	16,966	1,083	2,961	3,550	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	128	138	166	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	12	20	24	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43	0	359	1,072	1,286	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,152	1,381	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,270	5,119	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	10	12	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	43	0	275	98	118	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	73	136	163	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	291	0	964	387	464	90.00
91.00	09100	EMERGENCY	906	16,966	3,451	4,297	5,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,575	480,551	105,034	58,056	69,383	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	237	28,266	288	0	0	192.00
192.01	19201	RENTED SPACE	819	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	10,631	508,817	105,322	58,056	69,383	202.00

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		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	404,634					5.06
7.00	00700	OPERATION OF PLANT	22,735	538,038				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,033	15,711	110,526			8.00
9.00	00900	HOUSEKEEPING	9,528	29,690	1,351	219,174		9.00
10.00	01000	DIETARY	7,657	16,793	602	0	187,541	10.00
11.00	01100	CAFETERIA	8,133	13,151	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,298	3,750	0	51,195	0	13.00
15.00	01500	PHARMACY	9,475	7,245	0	4,581	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,903	9,960	0	2,708	0	16.00
17.00	01700	SOCIAL SERVICE	1,443	0	0	434	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,584	97,742	22,512	18,342	122,828	30.00
31.00	03100	INTENSIVE CARE UNIT	11,527	14,950	2,874	4,581	11,078	31.00
43.00	04300	NURSERY	3,090	2,150	645	4,886	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,539	18,694	8,833	8,653	53,635	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,128	49,389	36,528	19,493	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	927	4,414	161	1,223	0	52.00
53.00	05300	ANESTHESIOLOGY	4,886	2,875	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,733	36,276	10,942	8,541	0	54.00
60.00	06000	LABORATORY	31,509	21,858	33	6,342	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,351	12,742	328	6,029	0	65.00
66.00	06600	PHYSICAL THERAPY	23,150	26,070	3,514	14,854	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,643	866	0	3,279	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	60	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,180	15,083	0	3,054	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,241	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,327	678	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	118	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,479	8,214	26	2,316	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,165	3,520	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,539	7,292	0	0	0	90.00
91.00	09100	EMERGENCY	39,069	57,403	21,359	22,497	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	398,450	476,516	109,708	183,008	187,541	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	94	3,565	0	3,309	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,552	349	818	32,857	0	192.00
192.01	19201	RENTED SPACE	1,538	57,608	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	404,634	538,038	110,526	219,174	187,541	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	96,776					11.00
13.00	01300	NURSING ADMINISTRATION	0	145,290				13.00
15.00	01500	PHARMACY	2,717	0	83,541			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,084	0	0	119,055		16.00
17.00	01700	SOCIAL SERVICE	549	0	0	0	10,102	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,652	48,993	28	6,228	5,717	30.00
31.00	03100	INTENSIVE CARE UNIT	4,346	9,983	7	2,183	891	31.00
43.00	04300	NURSERY	1,531	4,004	7	430	495	43.00
44.00	04400	SKILLED NURSING FACILITY	4,526	12,639	0	1,769	2,999	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,929	27,807	1,224	20,267	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	383	1,001	2	449	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	2,681	3,085	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,625	1,131	2,869	33,695	0	54.00
60.00	06000	LABORATORY	10,952	3	71	13,601	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,025	841	511	7,437	0	65.00
66.00	06600	PHYSICAL THERAPY	2,762	0	0	6,090	0	66.00
68.00	06800	SPEECH PATHOLOGY	551	0	0	284	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29	0	0	41	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,100	9	53	2,206	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	75,794	2,369	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,783	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	21	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	546	403	0	202	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	412	0	0	279	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,042	3,955	56	797	0	90.00
91.00	09100	EMERGENCY	14,718	33,363	236	8,839	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,479	144,132	83,539	119,055	10,102	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	297	1,158	2	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	96,776	145,290	83,541	119,055	10,102	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,081,535	0	1,081,535		30.00
31.00	03100	INTENSIVE CARE UNIT		219,929	0	219,929		31.00
43.00	04300	NURSERY		29,166	0	29,166		43.00
44.00	04400	SKILLED NURSING FACILITY		255,182	0	255,182		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		1,446,647	0	1,446,647		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		29,916	0	29,916		52.00
53.00	05300	ANESTHESIOLOGY		75,592	0	75,592		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,303,380	0	1,303,380		54.00
60.00	06000	LABORATORY		363,482	0	363,482		60.00
65.00	06500	RESPIRATORY THERAPY		227,380	0	227,380		65.00
66.00	06600	PHYSICAL THERAPY		256,459	0	256,459		66.00
68.00	06800	SPEECH PATHOLOGY		12,485	0	12,485		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		210	0	210		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		171,432	0	171,432		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		93,937	0	93,937		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		41,326	0	41,326		73.00
74.00	07400	RENAL DIALYSIS		4,322	0	4,322		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		62,447	0	62,447		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		33,538	0	33,538		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		79,703	0	79,703		90.00
91.00	09100	EMERGENCY		701,209	0	701,209		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,489,277	0	6,489,277		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,525	0	23,525		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		206,629	0	206,629		192.00
192.01	19201	RENTED SPACE		327,543	0	327,543		192.01
194.00	07950	FUND DEVELOPMENT		0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	7,046,974	0	7,046,974		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	270,046					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,638,896				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,673	39,502	36,387,149			4.00
5.01	00540	NONPATIENT TELEPHONES	827	0	0	986		5.01
5.02	00550	DATA PROCESSING	2,961	358,807	921,036	58	29,090	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	7,654	0	309,034	11	323	5.03
5.04	00570	ADMITTING	1,019	583	709,594	31	2,263	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,988	0	807,689	20	1,939	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	20,992	47,914	3,698,609	239	2,263	5.06
7.00	00700	OPERATION OF PLANT	33,518	51,462	1,049,511	41	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,677	8,311	227,969	4	0	8.00
9.00	00900	HOUSEKEEPING	10,728	18,118	914,426	6	0	9.00
10.00	01000	DIETARY	6,068	24,483	412,131	21	2,586	10.00
11.00	01100	CAFETERIA	4,752	0	755,047	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,355	3,600	735,035	0	3,232	13.00
15.00	01500	PHARMACY	2,618	4,849	770,994	0	646	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,599	0	716,302	19	2,586	16.00
17.00	01700	SOCIAL SERVICE	0	0	150,073	2	323	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,318	110,157	4,347,903	92	2,909	30.00
31.00	03100	INTENSIVE CARE UNIT	5,402	33,290	1,153,749	16	1,939	31.00
43.00	04300	NURSERY	777	0	349,329	7	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,755	13,860	896,795	15	646	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,846	678,107	4,073,662	35	323	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	0	87,332	2	0	52.00
53.00	05300	ANESTHESIOLOGY	1,039	22,673	254,403	21	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,108	712,503	2,469,331	55	970	54.00
60.00	06000	LABORATORY	7,898	91,382	1,895,498	39	1,616	60.00
65.00	06500	RESPIRATORY THERAPY	4,604	69,359	899,768	20	970	65.00
66.00	06600	PHYSICAL THERAPY	9,420	18,820	2,581,860	15	970	66.00
68.00	06800	SPEECH PATHOLOGY	313	503	199,697	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	6,340	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,450	55,678	136,877	4	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	245	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	3,199	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,968	7,089	138,826	4	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,272	8,517	95,958	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,635	16,688	621,231	27	0	90.00
91.00	09100	EMERGENCY	20,742	135,324	3,796,592	84	970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	247,816	2,534,778	36,182,601	888	27,474	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	104,118	204,548	22	1,616	192.00
192.01	19201	RENTED SPACE	20,816	0	0	76	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,471,294	3,432,107	13,004,527	57,971	3,654,143	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.854454	1.300584	0.357393	58.794118	125.615091	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			137,154	10,631	508,817	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003769	10.781947	17.491131	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,169,195					5.03
5.04	00570	ADMITTING	17,859	329,049,989				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	73,854	0	329,049,989			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	172,417	0	0	-9,931,409	71,554,889	5.06
7.00	00700	OPERATION OF PLANT	87,669	0	0	0	4,020,355	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,776	0	0	0	536,291	8.00
9.00	00900	HOUSEKEEPING	151,276	0	0	0	1,684,888	9.00
10.00	01000	DIETARY	62,554	0	0	0	1,354,055	10.00
11.00	01100	CAFETERIA	128,356	0	0	0	1,438,186	11.00
13.00	01300	NURSING ADMINISTRATION	7,144	0	0	0	1,467,357	13.00
15.00	01500	PHARMACY	17,578	0	0	0	1,675,591	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,397,599	16.00
17.00	01700	SOCIAL SERVICE	15,968	0	0	0	255,116	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,646	17,203,757	17,203,757	0	7,353,542	30.00
31.00	03100	INTENSIVE CARE UNIT	4,073	6,031,281	6,031,281	0	2,038,367	31.00
43.00	04300	NURSERY	974	1,188,860	1,188,860	0	546,414	43.00
44.00	04400	SKILLED NURSING FACILITY	5,209	4,887,548	4,887,548	0	1,509,982	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	91,436	55,986,942	55,986,942	0	10,457,506	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	243	1,240,750	1,240,750	0	163,916	52.00
53.00	05300	ANESTHESIOLOGY	4,662	8,521,601	8,521,601	0	863,977	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,108	93,244,470	93,244,470	0	6,849,336	54.00
60.00	06000	LABORATORY	83,279	37,572,259	37,572,259	0	5,571,923	60.00
65.00	06500	RESPIRATORY THERAPY	38,485	20,543,476	20,543,476	0	2,007,268	65.00
66.00	06600	PHYSICAL THERAPY	12,023	16,823,292	16,823,292	0	4,093,745	66.00
68.00	06800	SPEECH PATHOLOGY	1,422	785,622	785,622	0	290,533	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	130	113,200	113,200	0	10,590	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,989	6,093,233	6,093,233	0	739,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,545,393	6,545,393	0	2,341,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,262,065	24,262,065	0	3,417,633	73.00
74.00	07400	RENAL DIALYSIS	0	58,754	58,754	0	20,811	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,051	558,417	558,417	0	261,608	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	812	771,540	771,540	0	206,019	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,700	2,201,177	2,201,177	0	979,413	90.00
91.00	09100	EMERGENCY	38,309	24,416,352	24,416,352	0	6,908,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,166,002	329,049,989	329,049,989	-9,931,409	70,461,338	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	16,557	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,193	0	0	0	804,948	192.00
192.01	19201	RENTED SPACE	0	0	0	0	272,046	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	733,931	1,300,506	1,939,960		9,931,409	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.627723	0.003952	0.005896		0.138794	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	105,322	58,056	69,383		404,634	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.090081	0.000176	0.000211		0.005655	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	194,414					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,677	1,091,083				8.00
9.00	00900	HOUSEKEEPING	10,728	13,337	52,530			9.00
10.00	01000	DIETARY	6,068	5,940	0	46,302		10.00
11.00	01100	CAFETERIA	4,752	0	0	0	36,159	11.00
13.00	01300	NURSING ADMINISTRATION	1,355	0	12,270	0	0	13.00
15.00	01500	PHARMACY	2,618	0	1,098	0	1,015	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,599	0	649	0	1,526	16.00
17.00	01700	SOCIAL SERVICE	0	0	104	0	205	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,318	222,232	4,396	30,325	7,716	30.00
31.00	03100	INTENSIVE CARE UNIT	5,402	28,376	1,098	2,735	1,624	31.00
43.00	04300	NURSERY	777	6,372	1,171	0	572	43.00
44.00	04400	SKILLED NURSING FACILITY	6,755	87,200	2,074	13,242	1,691	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,846	360,577	4,672	0	3,710	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	1,593	293	0	143	52.00
53.00	05300	ANESTHESIOLOGY	1,039	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,108	108,012	2,047	0	3,970	54.00
60.00	06000	LABORATORY	7,898	329	1,520	0	4,092	60.00
65.00	06500	RESPIRATORY THERAPY	4,604	3,237	1,445	0	1,504	65.00
66.00	06600	PHYSICAL THERAPY	9,420	34,692	3,560	0	1,032	66.00
68.00	06800	SPEECH PATHOLOGY	313	0	786	0	206	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,450	0	732	0	411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,968	259	555	0	204	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,272	0	0	0	154	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,635	0	0	0	763	90.00
91.00	09100	EMERGENCY	20,742	210,851	5,392	0	5,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	172,184	1,083,007	43,862	46,302	36,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	793	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	8,076	7,875	0	111	192.00
192.01	19201	RENTED SPACE	20,816	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,578,356	744,416	2,180,478	1,688,941	1,749,705	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.549518	0.682273	41.509195	36.476632	48.389198	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	538,038	110,526	219,174	187,541	96,776	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.767486	0.101299	4.172359	4.050387	2.676401	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 3:46 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	15.00	16.00	17.00	19.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	385,972					13.00
15.00	01500	PHARMACY	0	3,500,204				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	329,049,989			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	14,745		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	130,152	1,191	17,203,757	8,345	0	30.00
31.00	03100	INTENSIVE CARE UNIT	26,520	296	6,031,281	1,301	0	31.00
43.00	04300	NURSERY	10,636	298	1,188,860	722	0	43.00
44.00	04400	SKILLED NURSING FACILITY	33,577	15	4,887,548	4,377	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	73,871	51,269	55,986,942	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,659	74	1,240,750	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	112,344	8,521,601	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004	120,190	93,244,470	0	0	54.00
60.00	06000	LABORATORY	9	2,972	37,572,259	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,235	21,423	20,543,476	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	16,823,292	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	785,622	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	113,200	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25	2,241	6,093,233	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,175,551	6,545,393	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,262,065	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	58,754	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,071	0	558,417	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	771,540	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,508	2,351	2,201,177	0	0	90.00
91.00	09100	EMERGENCY	88,630	9,891	24,416,352	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	382,897	3,500,106	329,049,989	14,745	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,075	98	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,212,245	2,064,498	1,777,113	304,762	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.731620	0.589822	0.005401	20.668837	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	145,290	83,541	119,055	10,102	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.376426	0.023867	0.000362	0.685114	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,031,594		12,031,594	48	12,031,642	30.00
31.00	03100	INTENSIVE CARE UNIT	2,903,422		2,903,422	0	2,903,422	31.00
43.00	04300	NURSERY	803,666		803,666	0	803,666	43.00
44.00	04400	SKILLED NURSING FACILITY	2,898,394		2,898,394	0	2,898,394	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,704,722		13,704,722	301	13,705,023	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	266,382		266,382	0	266,382	52.00
53.00	05300	ANESTHESIOLOGY	1,120,648		1,120,648	0	1,120,648	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,051,075		9,051,075	1,106	9,052,181	54.00
60.00	06000	LABORATORY	6,997,326		6,997,326	0	6,997,326	60.00
65.00	06500	RESPIRATORY THERAPY	2,665,655	0	2,665,655	740	2,666,395	65.00
66.00	06600	PHYSICAL THERAPY	5,196,011	0	5,196,011	0	5,196,011	66.00
68.00	06800	SPEECH PATHOLOGY	385,065	0	385,065	0	385,065	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,203		13,203	0	13,203	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,054,768		1,054,768	0	1,054,768	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,574,719		4,574,719	0	4,574,719	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,028,789		4,028,789	0	4,028,789	73.00
74.00	07400	RENAL DIALYSIS	24,016		24,016	1,180	25,196	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	410,054		410,054	0	410,054	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	276,187		276,187	0	276,187	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,287,828		1,287,828	0	1,287,828	90.00
91.00	09100	EMERGENCY	9,635,573		9,635,573	0	9,635,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	854,524		854,524		854,524	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	80,183,621	0	80,183,621	3,375	80,186,996	200.00
201.00		Less Observation Beds	854,524		854,524		854,524	201.00
202.00		Total (see instructions)	79,329,097	0	79,329,097	3,375	79,332,472	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,360,865		16,360,865			30.00
31.00	03100	INTENSIVE CARE UNIT	6,031,281		6,031,281			31.00
43.00	04300	NURSERY	1,188,860		1,188,860			43.00
44.00	04400	SKILLED NURSING FACILITY	4,887,548		4,887,548			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,657,515	41,329,427	55,986,942	0.244784	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	941,399	299,351	1,240,750	0.214694	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,435,498	6,086,103	8,521,601	0.131507	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,514,907	85,729,563	93,244,470	0.097068	0.000000	54.00
60.00	06000	LABORATORY	11,706,939	25,865,320	37,572,259	0.186236	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,356,334	10,187,142	20,543,476	0.129757	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,707,976	12,115,316	16,823,292	0.308858	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	133,030	652,592	785,622	0.490140	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,773	109,427	113,200	0.116634	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,574,350	2,518,883	6,093,233	0.173105	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,614,588	1,930,805	6,545,393	0.698922	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,875,956	13,386,109	24,262,065	0.166053	0.000000	73.00
74.00	07400	RENAL DIALYSIS	58,754	0	58,754	0.408755	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	558,417	558,417	0.734315	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	771,540	771,540	0.357968	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	60,303	2,140,874	2,201,177	0.585063	0.000000	90.00
91.00	09100	EMERGENCY	3,268,178	21,148,174	24,416,352	0.394636	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	116,391	726,501	842,892	1.013800	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	103,494,445	225,555,544	329,049,989			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	103,494,445	225,555,544	329,049,989			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.244790	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.214694	52.00
53.00	05300	ANESTHESIOLOGY	0.131507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097080	54.00
60.00	06000	LABORATORY	0.186236	60.00
65.00	06500	RESPIRATORY THERAPY	0.129793	65.00
66.00	06600	PHYSICAL THERAPY	0.308858	66.00
68.00	06800	SPEECH PATHOLOGY	0.490140	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.116634	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173105	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.698922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166053	73.00
74.00	07400	RENAL DIALYSIS	0.428839	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.734315	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.357968	76.98
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.585063	90.00
91.00	09100	EMERGENCY	0.394636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.013800	92.00
		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: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,081,535	0	1,081,535	8,983	120.40	30.00
31.00	INTENSIVE CARE UNIT	219,929		219,929	1,301	169.05	31.00
43.00	NURSERY	29,166		29,166	722	40.40	43.00
44.00	SKILLED NURSING FACILITY	255,182		255,182	4,377	58.30	44.00
200.00	Total (lines 30-199)	1,585,812		1,585,812	15,383		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	4,749	571,780		30.00
31.00	INTENSIVE CARE UNIT	757	127,971		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	3,175	185,103		44.00
200.00	Total (lines 30-199)	8,681	884,854		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,446,647	55,986,942	0.025839	6,409,502	165,615	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,916	1,240,750	0.024111	3,768	91	52.00
53.00	05300	ANESTHESIOLOGY	75,592	8,521,601	0.008871	491,953	4,364	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,303,380	93,244,470	0.013978	6,533,710	91,328	54.00
60.00	06000	LABORATORY	363,482	37,572,259	0.009674	6,284,518	60,796	60.00
65.00	06500	RESPIRATORY THERAPY	227,380	20,543,476	0.011068	5,719,945	63,308	65.00
66.00	06600	PHYSICAL THERAPY	256,459	16,823,292	0.015244	1,595,116	24,316	66.00
68.00	06800	SPEECH PATHOLOGY	12,485	785,622	0.015892	84,116	1,337	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	210	113,200	0.001855	3,773	7	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	171,432	6,093,233	0.028135	1,112,693	31,306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,937	6,545,393	0.014352	2,508,030	35,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,326	24,262,065	0.001703	6,607,294	11,252	73.00
74.00	07400	RENAL DIALYSIS	4,322	58,754	0.073561	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	62,447	558,417	0.111829	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	33,538	771,540	0.043469	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	79,703	2,201,177	0.036209	31,589	1,144	90.00
91.00	09100	EMERGENCY	701,209	24,416,352	0.028719	1,750,384	50,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	76,814	842,892	0.091131	57,782	5,266	92.00
200.00		Total (lines 50-199)	4,980,279	300,581,435		39,194,173	546,394	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,983	0.00	4,749	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,301	0.00	757	0		31.00
43.00	04300	NURSERY	722	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	4,377	0.00	3,175	0		44.00
200.00		Total (lines 30-199)	15,383		8,681	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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
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: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	55,986,942	0.000000	0.000000	6,409,502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,240,750	0.000000	0.000000	3,768	52.00
53.00	05300	ANESTHESIOLOGY	0	8,521,601	0.000000	0.000000	491,953	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,244,470	0.000000	0.000000	6,533,710	54.00
60.00	06000	LABORATORY	0	37,572,259	0.000000	0.000000	6,284,518	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,543,476	0.000000	0.000000	5,719,945	65.00
66.00	06600	PHYSICAL THERAPY	0	16,823,292	0.000000	0.000000	1,595,116	66.00
68.00	06800	SPEECH PATHOLOGY	0	785,622	0.000000	0.000000	84,116	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	113,200	0.000000	0.000000	3,773	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,093,233	0.000000	0.000000	1,112,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,545,393	0.000000	0.000000	2,508,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,262,065	0.000000	0.000000	6,607,294	73.00
74.00	07400	RENAL DIALYSIS	0	58,754	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	558,417	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	771,540	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,201,177	0.000000	0.000000	31,589	90.00
91.00	09100	EMERGENCY	0	24,416,352	0.000000	0.000000	1,750,384	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	842,892	0.000000	0.000000	57,782	92.00
200.00		Total (lines 50-199)	0	300,581,435			39,194,173	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 3:46 pm

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,760,169	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	956,751	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,131,465	0		54.00
60.00	06000	LABORATORY	0	5,522,531	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,330,816	0		65.00
66.00	06600	PHYSICAL THERAPY	0	39,746	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,898	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	754,529	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	642,599	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,853,807	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	259,200	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	385,742	0		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	928,857	0		90.00
91.00	09100	EMERGENCY	0	5,068,370	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	437,520	0		92.00
200.00		Total (lines 50-199)	0	61,096,000	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.244784	11,760,169	0	0	2,878,701	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.214694	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.131507	956,751	0	0	125,819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097068	26,131,465	0	0	2,536,529	54.00
60.00	06000	LABORATORY	0.186236	5,522,531	0	0	1,028,494	60.00
65.00	06500	RESPIRATORY THERAPY	0.129757	2,330,816	0	0	302,440	65.00
66.00	06600	PHYSICAL THERAPY	0.308858	39,746	0	0	12,276	66.00
68.00	06800	SPEECH PATHOLOGY	0.490140	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.116634	23,898	0	0	2,787	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173105	754,529	0	0	130,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.698922	642,599	426	0	449,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166053	5,853,807	0	91,070	972,042	73.00
74.00	07400	RENAL DIALYSIS	0.408755	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.734315	259,200	0	0	190,334	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.357968	385,742	0	0	138,083	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.585063	928,857	0	0	543,440	90.00
91.00	09100	EMERGENCY	0.394636	5,068,370	969	0	2,000,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.013800	437,520	0	0	443,558	92.00
200.00		Subtotal (see instructions)		61,096,000	1,395	91,070	11,754,404	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		61,096,000	1,395	91,070	11,754,404	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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	298	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,122		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
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	382	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	680	15,122		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	680	15,122		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058
Component CCN: 14-5951

Period:
From 10/01/2015
To 09/30/2016

Worksheet D
Part IV
Date/Time Prepared:
2/23/2017 3:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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
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: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	55,986,942	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,240,750	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	8,521,601	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93,244,470	0.000000	0.000000	121,906	54.00
60.00	06000	LABORATORY	0	37,572,259	0.000000	0.000000	526,368	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,543,476	0.000000	0.000000	1,110,808	65.00
66.00	06600	PHYSICAL THERAPY	0	16,823,292	0.000000	0.000000	1,715,349	66.00
68.00	06800	SPEECH PATHOLOGY	0	785,622	0.000000	0.000000	17,504	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	113,200	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,093,233	0.000000	0.000000	244,065	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,545,393	0.000000	0.000000	1,947	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,262,065	0.000000	0.000000	888,230	73.00
74.00	07400	RENAL DIALYSIS	0	58,754	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	558,417	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	771,540	0.000000	0.000000	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,201,177	0.000000	0.000000	11,689	90.00
91.00	09100	EMERGENCY	0	24,416,352	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	842,892	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	300,581,435			4,637,866	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.244784	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.214694	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.131507	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097068	0	0	0	0	54.00
60.00	06000	LABORATORY	0.186236	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.129757	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.308858	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.490140	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.116634	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173105	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.698922	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166053	0	0	1,814	0	73.00
74.00	07400	RENAL DIALYSIS	0.408755	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.734315	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.357968	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.585063	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.394636	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.013800	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	1,814	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	1,814	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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	0	301		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
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
200.00		Subtotal (see instructions)	0	301		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	301		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,983	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,983	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,345	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,749	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)	12,031,642	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)	12,031,642	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)	12,031,642	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)	1,339.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,360,716	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)	6,360,716	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 3:46 pm

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	2,903,422	1,301	2,231.68	757	1,689,382	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)	8,526,441	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	16,576,539	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)	699,751	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	546,394	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,246,145	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	15,330,394	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)	638	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,339.38	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	854,524	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

	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	1,081,535	12,031,642	0.089891	854,524	76,814	90.00
91.00	Nursing School cost	0	12,031,642	0.000000	854,524	0	91.00
92.00	Allied health cost	0	12,031,642	0.000000	854,524	0	92.00
93.00	All other Medical Education	0	12,031,642	0.000000	854,524	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/23/2017 3:46 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,377	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,377	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)	4,377	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)	3,175	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,898,394	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,898,394	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,898,394	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,898,394	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	662.19	71.00
72.00	Program routine service cost (line 9 x line 71)	2,102,453	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,102,453	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,102,453	83.00
84.00	Program inpatient ancillary services (see instructions)	990,317	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,092,770	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/23/2017 3:46 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/23/2017 3:46 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		7,960,737		30.00
31.00	03100	INTENSIVE CARE UNIT		3,537,197		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.244790	6,409,502	1,568,982	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.214694	3,768	809	52.00
53.00	05300	ANESTHESIOLOGY	0.131507	491,953	64,695	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097080	6,533,710	634,293	54.00
60.00	06000	LABORATORY	0.186236	6,284,518	1,170,403	60.00
65.00	06500	RESPIRATORY THERAPY	0.129793	5,719,945	742,409	65.00
66.00	06600	PHYSICAL THERAPY	0.308858	1,595,116	492,664	66.00
68.00	06800	SPEECH PATHOLOGY	0.490140	84,116	41,229	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.116634	3,773	440	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173105	1,112,693	192,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.698922	2,508,030	1,752,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166053	6,607,294	1,097,161	73.00
74.00	07400	RENAL DIALYSIS	0.428839	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.734315	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.357968	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.585063	31,589	18,482	90.00
91.00	09100	EMERGENCY	0.394636	1,750,384	690,765	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.013800	57,782	58,579	92.00
200.00		Total (sum of lines 50-94 and 96-98)		39,194,173	8,526,441	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		39,194,173		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2015 To 09/30/2016	Worksheet D-3 Date/Time Prepared: 2/23/2017 3:46 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.244784	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.214694	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.131507	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.097068	121,906	11,833	54.00
60.00	06000	LABORATORY	0.186236	526,368	98,029	60.00
65.00	06500	RESPIRATORY THERAPY	0.129757	1,110,808	144,135	65.00
66.00	06600	PHYSICAL THERAPY	0.308858	1,715,349	529,799	66.00
68.00	06800	SPEECH PATHOLOGY	0.490140	17,504	8,579	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.116634	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173105	244,065	42,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.698922	1,947	1,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166053	888,230	147,493	73.00
74.00	07400	RENAL DIALYSIS	0.408755	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.734315	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.357968	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.585063	11,689	6,839	90.00
91.00	09100	EMERGENCY	0.394636	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.013800	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,637,866	990,317	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,637,866		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/23/2017 3:46 pm
	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)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	9,835,760	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)	231,823	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	93.28	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)	4.95	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.53	31.00
32.00	Sum of lines 30 and 31	24.48	32.00
33.00	Allowable disproportionate share percentage (see instructions)	9.41	33.00
34.00	Disproportionate share adjustment (see instructions)	231,386	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/23/2017 3:46 pm
	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)	0	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000040347	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	258,471	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	258,471	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	258,471		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 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	10,557,440		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	12,633,647		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		12,633,647	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		813,827	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment			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 intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		13,447,474	59.00
60.00	Primary payer payments		8,712	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		13,438,762	61.00
62.00	Deductibles billed to program beneficiaries		1,405,796	62.00
63.00	Coinsurance billed to program beneficiaries		10,549	63.00
64.00	Allowable bad debts (see instructions)		394,265	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		256,272	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		366,119	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,278,689	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)		0	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)		-46,657	70.93
70.94	HRR adjustment amount (see instructions)		-69,833	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/23/2017 3:46 pm
	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)		135,029	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		12,027,170	71.00
71.01	Sequestration adjustment (see instructions)		240,543	71.01
72.00	Interim payments		11,928,795	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)		-142,168	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)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/23/2017 3:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,802	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,754,404	2.00
3.00	PPS payments	9,502,028	3.00
4.00	Outlier payment (see instructions)	33,248	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)	15,802	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	92,465	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)	92,465	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	92,465	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	76,663	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)	15,802	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)	9,535,276	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)	2,068,015	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)	7,483,063	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)	7,483,063	30.00
31.00	Primary payer payments	205	31.00
32.00	Subtotal (line 30 minus line 31)	7,482,858	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)	502,666	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	326,733	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	456,449	36.00
37.00	Subtotal (see instructions)	7,809,591	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	7,809,591	40.00
40.01	Sequestration adjustment (see instructions)	156,192	40.01
41.00	Interim payments	7,686,930	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-33,531	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/23/2017 3:46 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	301	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	301	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,814	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)	1,814	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,814	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,513	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)	301	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	301	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)	301	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	301	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	301	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	301	40.00
40.01	Sequestration adjustment (see instructions)	6	40.01
41.00	Interim payments	409	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-114	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2017 3:46 pm

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		11,928,795		7,686,930	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)		11,928,795		7,686,930	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		142,168		33,531	6.02
7.00	Total Medicare program liability (see instructions)		11,786,627		7,653,399	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: 14-0058	Period:	Worksheet E-1
Component CCN: 14-5951	From 10/01/2015 To 09/30/2016	Part I Date/Time Prepared: 2/23/2017 3:46 pm
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,026,518		409	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,026,518		409	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		114	6.02
7.00	Total Medicare program liability (see instructions)		1,026,518		295	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: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/23/2017 3:46 pm
	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	3,192	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	5,506	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	658	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	9,646	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	329,049,989	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,465,282	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)	386,520	8.00
9.00	Sequestration adjustment amount (see instructions)	7,730	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	378,790	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	378,790	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 2/23/2017 3:46 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,143,581	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,143,581	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	96,114	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,047,467	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,047,467	15.00
15.01	Sequestration adjustment (see instructions)	20,949	15.01
16.00	Interim payments	1,026,518	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/23/2017 3:46 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,166,961	0	0	0	1.00
2.00	Temporary investments	4,265,696	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	67,555,950	0	0	0	4.00
5.00	Other receivable	4,978,174	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-52,158,120	0	0	0	6.00
7.00	Inventory	1,611,175	0	0	0	7.00
8.00	Prepaid expenses	1,482,325	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	30,902,161	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	735,200	0	0	0	12.00
13.00	Land improvements	383,451	0	0	0	13.00
14.00	Accumulated depreciation	-96,274	0	0	0	14.00
15.00	Buildings	17,010,860	0	0	0	15.00
16.00	Accumulated depreciation	-1,030,386	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	20,596,083	0	0	0	19.00
20.00	Accumulated depreciation	-6,232,098	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	31,366,836	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	69,483,299	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	29,703,180	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	99,186,479	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	161,455,476	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,262,205	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,767,680	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	4,397,750	0	0	0	43.00
44.00	Other current liabilities	1,529,660	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14,957,295	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,409,867	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	31,142,813	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	32,552,680	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47,509,975	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	113,945,501				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)	113,945,501	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	161,455,476	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/23/2017 3:46 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		106,263,449		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,134,941				2.00
3.00	Total (sum of line 1 and line 2)		122,398,390		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)		122,398,390		0		11.00
12.00	CHANGE IN NET ASSETS	8,452,889		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)		8,452,889		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		113,945,501		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	CHANGE IN NET ASSETS		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: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/23/2017 3:46 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	16,419,992		16,419,992	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	6,426,328		6,426,328	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)	22,846,320		22,846,320	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,068,609		6,068,609	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)	6,068,609		6,068,609	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	28,914,929		28,914,929	17.00
18.00	Ancillary services	72,946,002	207,512,278	280,458,280	18.00
19.00	Outpatient services	3,509,360	24,556,087	28,065,447	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				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	191,885	191,885	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	105,370,291	232,260,250	337,630,541	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		89,213,929		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		89,213,929		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/23/2017 3:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	337,630,541	1.00
2.00	Less contractual allowances and discounts on patients' accounts	238,625,885	2.00
3.00	Net patient revenues (line 1 minus line 2)	99,004,656	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	89,213,929	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,790,727	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,390,000	6.00
7.00	Income from investments	2,390,234	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	420,336	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	27,184	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	10,101	21.00
22.00	Rental of hospital space	365,923	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	534,537	24.00
24.01	LIFELINE	420,300	24.01
24.02	EHR	431,623	24.02
25.00	Total other income (sum of lines 6-24)	5,990,238	25.00
26.00	Total (line 5 plus line 25)	15,780,965	26.00
27.00	NON OPERATING EXPENSE	78,290	27.00
27.01	CHANGE IN INTEREST	858,816	27.01
27.02	NI ON TEMP RESTREICTED FUNDS	-4,394	27.02
27.03	UNREALIZED GAINS	-1,286,688	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	-353,976	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,134,941	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0058	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 2/23/2017 3:46 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	782,990	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	30,837	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)	27.51	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)	813,827	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