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: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/23/2017 6:50 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/23/2017 Time: 6:50 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 SAINT JAMES HOSPITAL (14-0161) 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	36,561	23,242	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	36,561	23,242	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2017 6:48 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2500 WEST REYNOLDS STREET	PO Box:			1.00
2.00	City: PONTIAC	State: IL	Zip Code: 61764	County: LIVINGSTON	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	SAINT JAMES HOSPITAL	140161	99914	1	07/01/1966	N	P	O	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	ST JAMES HOSPITAL SWING	14U161	99914		10/10/2002	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									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)	1		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	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	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.	274	179	0	0	477	33	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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 6:48 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)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 6:48 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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 6:48 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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.					109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	1	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.	Y	Y	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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2017 6:48 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	149006	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 06101	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	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.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/23/2017 6:48 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)			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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2017 6:48 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	02/15/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/07/2017	Y	02/07/2017	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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2017 6:48 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.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					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.					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.					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.					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.					35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					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.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	LOUIS		RAPTOPOULOS		41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(309)-624-9230		LOUIS.C.RAPTOPOULO@OSFHEALTHCARE.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/23/2017 6:48 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.	GOVT REIMBURSEMENT SENIOR ANALYST		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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2017 6:48 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	37	13,542	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)		37	13,542	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,830	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)		42	15,372	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)		42				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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2017 6:48 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)	2,586	200	4,159			1.00
2.00	HMO and other (see instructions)	599	656				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	215	0	333			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)	2,801	200	4,492			7.00
8.00	INTENSIVE CARE UNIT	472	53	1,009			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		21	400			13.00
14.00	Total (see instructions)	3,273	274	5,901	0.00	307.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	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	307.00	27.00
28.00	Observation Bed Days		129	837			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	33	51			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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2017 6:48 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	877	258	1,841	1.00
2.00	HMO and other (see instructions)			181	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	877	258	1,841	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2017 6:48 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	18,176,135	-50,145	18,125,990	577,499.00	31.39	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		15,011	0	15,011	391.00	38.39	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		0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,740,075	-1,176	2,738,899	38,762.00	70.66	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		494,583	0	494,583	7,925.00	62.41	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		300,897	0	300,897	2,603.00	115.60	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		4,010,854	0	4,010,854	77,874.00	51.50	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,074,425	0	5,074,425			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		594,235	0	594,235			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		4,224	0	4,224			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			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	-30,978	32,444	1,466	54.00	27.15	26.00
27.00	Administrative & General	5.00	1,791,402	-3,833	1,787,569	39,493.00	45.26	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2017 6:48 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.)		16,330	0	16,330	84.00	194.40	28.00
29.00	Maintenance & Repairs	6.00	58,603	-120	58,483	2,085.00	28.05	29.00
30.00	Operation of Plant	7.00	442,276	-905	441,371	18,561.00	23.78	30.00
31.00	Laundry & Linen Service	8.00	21,940	-45	21,895	1,963.00	11.15	31.00
32.00	Housekeeping	9.00	488,223	-9,329	478,894	38,005.00	12.60	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	448,876	-340,793	108,083	6,760.00	15.99	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	338,424	338,424	20,889.00	16.20	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	994,270	-237,288	756,982	19,693.00	38.44	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	373,359	-764	372,595	15,353.00	24.27	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 2/23/2017 6:48 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)		18,192,465	-50,145	18,142,320	577,583.00	31.41	1.00
2.00	Excluded area salaries (see instructions)		2,740,075	-1,176	2,738,899	38,762.00	70.66	2.00
3.00	Subtotal salaries (line 1 minus line 2)		15,452,390	-48,969	15,403,421	538,821.00	28.59	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,806,334	0	4,806,334	88,402.00	54.37	4.00
5.00	Subtotal wage-related costs (see inst.)		5,078,649	0	5,078,649	0.00	32.97	5.00
6.00	Total (sum of lines 3 thru 5)		25,337,373	-48,969	25,288,404	627,223.00	40.32	6.00
7.00	Total overhead cost (see instructions)		4,604,301	-222,209	4,382,092	162,940.00	26.89	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 2/23/2017 6:48 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,159,991	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)	293,496	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)	3,046,217	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)	0	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)	18,802	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	42,151	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	1,088,350	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	1,546	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	22,330	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,672,883	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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 2/23/2017 6:48 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	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			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			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet S-7 Date/Time Prepared: 2/23/2017 6:48 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.	Y	10/10/2002	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	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	7	7	19.00
20.00		RHA	0	45	45	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	14	14	22.00
23.00		RMA	0	44	44	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	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	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	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	6	6	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	13	13	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	22	22	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	53	53	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	0	0	0	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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-7 | Date/Time Prepared: 2/23/2017 6:48 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	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	11	11	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	215	215	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).	16974	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	0	0.00		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)	0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/23/2017 6:48 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)	0.184464	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,758,598	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	37,404,017	6.00
7.00	Medicaid cost (line 1 times line 6)	6,899,695	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)	1,141,097	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	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)	1,141,097	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	2,427,621	618,417	3,046,038	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	447,809	114,076	561,885	21.00
22.00	Partial payment by patients approved for charity care	2,775	54,471	57,246	22.00
23.00	Cost of charity care (line 21 minus line 22)	445,034	59,605	504,639	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,526,874	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	263,622	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,263,252	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	601,953	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,106,592	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,247,689	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/23/2017 6:48 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		1,670,959	1,670,959	30,599	1,701,558	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,841,809	1,841,809	19,364	1,861,173	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-30,978	5,983,894	5,952,916	64,157	6,017,073	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,791,402	7,283,009	9,074,411	-55,266	9,019,145	5.00
6.00	00600	MAINTENANCE & REPAIRS	58,603	96,576	155,179	-120	155,059	6.00
7.00	00700	OPERATION OF PLANT	442,276	1,181,158	1,623,434	-905	1,622,529	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,940	133,217	155,157	-45	155,112	8.00
9.00	00900	HOUSEKEEPING	488,223	34,527	522,750	-3,320	519,430	9.00
10.00	01000	DIETARY	448,876	158,764	607,640	-460,736	146,904	10.00
11.00	01100	CAFETERIA	0	0	0	458,367	458,367	11.00
13.00	01300	NURSING ADMINISTRATION	994,270	76,989	1,071,259	-256,626	814,633	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	373,359	-19,201	354,158	-764	353,394	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,234,166	382,902	2,617,068	-11,180	2,605,888	30.00
31.00	03100	INTENSIVE CARE UNIT	717,572	198,648	916,220	-2,990	913,230	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,713,402	2,543,351	4,256,753	-1,831,555	2,425,198	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	563,315	563,315	-54,030	509,285	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	466,171	70,761	536,932	-2,163	534,769	54.00
54.10	03630	ULTRA SOUND	212,475	40,623	253,098	-918	252,180	54.10
54.20	03440	MAMMOGRAPHY	140,989	117,918	258,907	-636	258,271	54.20
56.00	05600	RADIOISOTOPE	78,854	174,057	252,911	-310	252,601	56.00
57.00	05700	CT SCAN	161,130	437,140	598,270	-987	597,283	57.00
58.00	05800	MRI	170,976	346,150	517,126	-902	516,224	58.00
60.00	06000	LABORATORY	872,626	1,384,794	2,257,420	-184,506	2,072,914	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	180,670	180,670	63.00
65.00	06500	RESPIRATORY THERAPY	311,894	124,047	435,941	-48,522	387,419	65.00
66.00	06600	PHYSICAL THERAPY	649,565	11,597	661,162	141,332	802,494	66.00
67.00	06700	OCCUPATIONAL THERAPY	248,756	-1,074	247,682	47,677	295,359	67.00
68.00	06800	SPEECH PATHOLOGY	170,559	82,843	253,402	54,729	308,131	68.00
69.00	06900	ELECTROCARDIOLOGY	215,538	30,138	245,676	-939	244,737	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	216,700	92,397	309,097	-912	308,185	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124,253	200,453	324,706	713,034	1,037,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,191,712	1,191,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	623,978	1,685,751	2,309,729	61,846	2,371,575	73.00
76.00	03950	DIABETES SERVICES	64,806	1,357	66,163	-283	65,880	76.00
76.97	07697	CARDIAC REHABILITATION	73,368	4,980	78,348	-347	78,001	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,380,311	2,146,960	3,527,271	-43,349	3,483,922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,436,060	29,080,809	44,516,869	1,176	44,518,045	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,565	10,230	31,795	-44	31,751	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,702,124	3,739,503	6,441,627	-1,099	6,440,528	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	6,986	392,021	399,007	-14	398,993	192.02
192.03	19203	PULMONARY FUNCTION	9,400	66	9,466	-19	9,447	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	18,176,135	33,222,629	51,398,764	0	51,398,764	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/23/2017 6:48 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	147,007	1,848,565		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	29,028	1,890,201		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-209,701	5,807,372		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,453,794	6,565,351		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	155,059		6.00
7.00	00700	OPERATION OF PLANT	-40,623	1,581,906		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	155,112		8.00
9.00	00900	HOUSEKEEPING	0	519,430		9.00
10.00	01000	DIETARY	-24,753	122,151		10.00
11.00	01100	CAFETERIA	-144,604	313,763		11.00
13.00	01300	NURSING ADMINISTRATION	-625	814,008		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-22,595	330,799		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-12,025	2,593,863		30.00
31.00	03100	INTENSIVE CARE UNIT	0	913,230		31.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,425,198		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-424,423	84,862		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,486	532,283		54.00
54.10	03630	ULTRA SOUND	0	252,180		54.10
54.20	03440	MAMMOGRAPHY	0	258,271		54.20
56.00	05600	RADIOISOTOPE	-727	251,874		56.00
57.00	05700	CT SCAN	793	598,076		57.00
58.00	05800	MRI	-782	515,442		58.00
60.00	06000	LABORATORY	-16,717	2,056,197		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	180,670		63.00
65.00	06500	RESPIRATORY THERAPY	0	387,419		65.00
66.00	06600	PHYSICAL THERAPY	-115	802,379		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	295,359		67.00
68.00	06800	SPEECH PATHOLOGY	-1,387	306,744		68.00
69.00	06900	ELECTROCARDIOLOGY	0	244,737		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,308	305,877		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-30,787	1,006,953		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,191,712		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-229,048	2,142,527		73.00
76.00	03950	DIABETES SERVICES	-500	65,380		76.00
76.97	07697	CARDIAC REHABILITATION	-11,025	66,976		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,941,395	1,542,527		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,393,592	39,124,453		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	31,751		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,440,528		192.00
192.01	19201	CARDIAC PHASE III	0	0		192.01
192.02	19202	FUND DEVELOPMENT	0	398,993		192.02
192.03	19203	PULMONARY FUNCTION	0	9,447		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-5,393,592	46,005,172		200.00

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/23/2017 6:48 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TEAM AWARD RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	32,510	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	TOTALS		32,510	0	
	B - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	49,963	1.00
	0		0	49,963	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	339,118	119,943	1.00
	0		339,118	119,943	
	D - BLOOD				
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	180,670	1.00
	0		0	180,670	
	E - REHAB ADMIN RECLASS				
1.00	PHYSICAL THERAPY	66.00	133,569	11,001	1.00
2.00	OCCUPATIONAL THERAPY	67.00	50,037	4,121	2.00
3.00	SPEECH PATHOLOGY	68.00	51,193	4,216	3.00
	0		234,799	19,338	
	G - IMPLANT DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,191,712	1.00
2.00		0.00	0	0	2.00
	0		0	1,191,712	
	H - MED SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	714,023	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	714,023	
	I - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	63,123	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	63,123	
	J - DISABILITY				
1.00		0.00	0	0	1.00
2.00	HOUSEKEEPING	9.00	0	6,009	2.00
4.00	ADULTS & PEDIATRICS	30.00	0	6,518	4.00
6.00	LABORATORY	60.00	0	2,391	6.00
7.00	MRI	58.00	0	2,471	7.00
8.00	EMERGENCY	91.00	0	1,387	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	126	9.00
	0		0	18,902	

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/23/2017 6:48 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	L - GAMMA TEST POSTED TO SAL				
1.00	RADIOISOTOPE	56.00	0	1,000	1.00
	TOTALS		0	1,000	
	M - RECLASS PTO DONATE ERR POSTED TO SAL				
1.00	ADMINISTRATIVE & GENERAL	5.00	1,470	0	1.00
	TOTALS		1,470	0	
	Z - VACATION ACCRUAL RECLASS				
1.00		0.00	0	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
37.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	31,713	37.00
	0		0	31,713	
500.00	Grand Total: Increases		607,897	2,390,387	500.00

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/23/2017 6:48 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TEAM AWARD RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	1,619	0	0		1.00
2.00	HOUSEKEEPING	9.00	2,338	0	0		2.00
3.00	DIETARY	10.00	1,453	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	937	0	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	5,719	0	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	1,331	0	0		6.00
7.00	OPERATING ROOM	50.00	4,577	0	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	1,211	0	0		8.00
9.00	ULTRA SOUND	54.10	484	0	0		9.00
10.00	MAMMOGRAPHY	54.20	348	0	0		10.00
11.00	RADIOISOTOPE	56.00	151	0	0		11.00
12.00	CT SCAN	57.00	303	0	0		12.00
13.00	MRI	58.00	454	0	0		13.00
14.00	LABORATORY	60.00	2,059	0	0		14.00
15.00	RESPIRATORY THERAPY	65.00	832	0	0		15.00
16.00	PHYSICAL THERAPY	66.00	1,639	0	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	605	0	0		17.00
18.00	SPEECH PATHOLOGY	68.00	227	0	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	499	0	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	469	0	0		20.00
21.00	DIABETES SERVICES	76.00	151	0	0		21.00
22.00	CARDIAC REHABILITATION	76.97	197	0	0		22.00
23.00	EMERGENCY	91.00	3,808	0	0		23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,099	0	0		24.00
	TOTALS		32,510	0			
	B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	49,963	12		1.00
	0		0	49,963			
	C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	339,118	119,943	0		1.00
	0		339,118	119,943			
	D - BLOOD						
1.00	LABORATORY	60.00	0	180,670	0		1.00
	0		0	180,670			
	E - REHAB ADMIN RECLASS						
1.00	NURSING ADMINISTRATION	13.00	234,799	19,338	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		234,799	19,338			
	G - IMPLANT DEVICE						
1.00	OPERATING ROOM	50.00	0	1,190,977	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	735	0		2.00
	0		0	1,191,712			
	H - MED SUPPLIES CHARGED TO PATIENTS						
1.00	OPERATING ROOM	50.00	0	626,806	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	34,898	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	47,053	0		3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	5,266	0		4.00
	0		0	714,023			
	I - DRUGS CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	914	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	193	0		2.00
3.00	OPERATING ROOM	50.00	0	5,698	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	19,132	0		4.00
5.00	CT SCAN	57.00	0	355	0		5.00
6.00	MRI	58.00	0	104	0		6.00
7.00	EMERGENCY	91.00	0	36,727	0		7.00
	0		0	63,123			
	J - DISABILITY						
1.00		0.00	0	0	0		1.00
2.00	HOUSEKEEPING	9.00	6,009	0	0		2.00
4.00	ADULTS & PEDIATRICS	30.00	6,518	0	0		4.00
6.00	LABORATORY	60.00	2,391	0	0		6.00
7.00	MRI	58.00	2,471	0	0		7.00
8.00	EMERGENCY	91.00	1,387	0	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	126	0	0		9.00
	0		18,902	0			
	L - GAMMA TEST POSTED TO SAL						
1.00	RADIOISOTOPE	56.00	1,000	0	0		1.00
	TOTALS		1,000	0			

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/23/2017 6:48 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	M - RECLASS PTO DONATE ERR POSTED TO SAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,470	0		1.00
	TOTALS		0	1,470			
	Z - VACATION ACCRUAL RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,684	0	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	120	0	0		2.00
3.00	OPERATION OF PLANT	7.00	905	0	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	45	0	0		4.00
5.00	HOUSEKEEPING	9.00	982	0	0		5.00
6.00	DIETARY	10.00	222	0	0		6.00
7.00	CAFETERIA	11.00	694	0	0		7.00
8.00	NURSING ADMINISTRATION	13.00	1,552	0	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	764	0	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	4,547	0	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	1,466	0	0		11.00
12.00	OPERATING ROOM	50.00	3,497	0	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	952	0	0		13.00
14.00	ULTRA SOUND	54.10	434	0	0		14.00
15.00	MAMMOGRAPHY	54.20	288	0	0		15.00
16.00	RADIOISOTOPE	56.00	159	0	0		16.00
17.00	CT SCAN	57.00	329	0	0		17.00
18.00	MRI	58.00	344	0	0		18.00
19.00	LABORATORY	60.00	1,777	0	0		19.00
20.00	RESPIRATORY THERAPY	65.00	637	0	0		20.00
21.00	PHYSICAL THERAPY	66.00	1,599	0	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	610	0	0		22.00
23.00	SPEECH PATHOLOGY	68.00	453	0	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	440	0	0		24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	443	0	0		25.00
26.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	254	0	0		26.00
27.00	DRUGS CHARGED TO PATIENTS	73.00	1,277	0	0		27.00
28.00	DIABETES SERVICES	76.00	132	0	0		28.00
29.00	CARDIAC REHABILITATION	76.97	150	0	0		29.00
30.00	EMERGENCY	91.00	2,814	0	0		30.00
31.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	44	0	0		31.00
33.00	FUND DEVELOPMENT	192.02	14	0	0		33.00
34.00	PULMONARY FUNCTION	192.03	19	0	0		34.00
37.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	66	0	0		37.00
	0		31,713	0			
500.00	Grand Total: Decreases		658,042	2,340,242			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2017 6:48 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	600,013	0	0	0	0	1.00
2.00	Land Improvements	2,287,903	134,900	0	134,900	32,328	2.00
3.00	Buildings and Fixtures	38,006,533	424,130	0	424,130	293,243	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	27,775,034	1,275,649	0	1,275,649	4,983,712	5.00
6.00	Movable Equipment	96,040	0	0	0	28,868	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,765,523	1,834,679	0	1,834,679	5,338,151	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	68,765,523	1,834,679	0	1,834,679	5,338,151	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	600,013	0	1.00
2.00	Land Improvements	2,390,475	0	2.00
3.00	Buildings and Fixtures	38,137,420	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	24,066,971	0	5.00
6.00	Movable Equipment	67,172	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,262,051	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	65,262,051	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2017 6:48 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	1,670,959	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,841,809	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,512,768	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	1,670,959		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,841,809		2.00
3.00	Total (sum of lines 1-2)	0	3,512,768		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2017 6:48 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	38,137,420	0	38,137,420	0.612437	30,599	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,134,143	0	24,134,143	0.387563	19,364	2.00
3.00	Total (sum of lines 1-2)	62,271,563	0	62,271,563	1.000000	49,963	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	30,599	1,817,966	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	19,364	1,870,837	0	2.00
3.00	Total (sum of lines 1-2)	0	0	49,963	3,688,803	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	30,599	0	0	1,848,565	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	19,364	0	0	1,890,201	2.00
3.00	Total (sum of lines 1-2)	0	49,963	0	0	3,738,766	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/23/2017 6:48 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		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	-2,784	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,421,185			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	-831,990			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-144,604	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-3,518	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-22,595	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	-11,349	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-30,003	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUITMENT	A	-72	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/23/2017 6:48 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	
34.00	LOBBYING DUES INCLUDING AHA AND IHA	A	-23,757	ADMINISTRATIVE & GENERAL	5.00	0	34.00
36.00	PRE EMPLOYMENT PHYSICALS	A	-31,996	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
38.00	EMERGENCY MEDICAL TRANSPORTATIO	B	-32,280	EMERGENCY	91.00	0	38.00
39.00	LAB NON PATIENT INCOME	B	-1,100	LABORATORY	60.00	0	39.00
39.01	CARDIAC REHAB	B	-9,635	CARDIAC REHABILITATION	76.97	0	39.01
40.00	RADIOLOGY - SILVER RECOVERY & F	B	-65	RADIOLOGY-DIAGNOSTIC	54.00	0	40.00
41.00	PEDIATRIC DEVELOPMENT	B	-115	PHYSICAL THERAPY	66.00	0	41.00
42.00	AUDIOLOGY	B	-1,387	SPEECH PATHOLOGY	68.00	0	42.00
43.00			0		0.00	0	43.00
44.00			0		0.00	0	44.00
45.00	HOSPITAL ADMIN - FARM INCOME &	B	-25,210	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	REYNOLDS STREET PROPERTY - RENT	B	-13,200	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	CHAPLAINCY - CANDLES & RENTAL I	B	-10,113	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.00			0		0.00	0	49.00
49.01	DIABETES SERVICES	B	-500	DIABETES SERVICES	76.00	0	49.01
49.02	CABLE	A	-10,865	OPERATION OF PLANT	7.00	0	49.02
49.11	DIETARY O/P REVENUE	B	-13,404	DIETARY	10.00	0	49.11
49.12	MEDICAID ASSESSMENT	A	-1,525,348	ADMINISTRATIVE & GENERAL	5.00	0	49.12
49.13	REVENUE CYCLE ADMINISTRATION	B	-240	ADMINISTRATIVE & GENERAL	5.00	0	49.13
49.15	340B PHARMACY	A	-225,530	DRUGS CHARGED TO PATIENTS	73.00	0	49.15
49.16	MARKETING AND ADVERTISING	A	-122	EMERGENCY	91.00	0	49.16
49.17	MARKETING AND ADVERTISING	A	-625	NURSING ADMINISTRATION	13.00	0	49.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,393,592				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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2017 6:48 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	CORP OFF CHARGE - BUILDING	147,007	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CORP OFF CHARGE - EQUIP	734,835	705,807	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CORP OFF CHARGE - EB	690,059	867,764	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OFFICE CHARGES - A	4,389,513	5,519,904	3.01
3.02	7.00	OPERATION OF PLANT	CORPORATE OFFICE CHARGES - P	115,555	145,313	3.02
4.00	0.00		CORPORATE OFFICE CHARGES - N	0	0	4.00
4.01	71.00	MEDICAL SUPPLIES CHARGED TO	CORPORATE OFFICE CHARGES - M	119,552	150,339	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OFFICE-INTEREST	363,753	0	4.02
4.03	54.00	RADIOLOGY-DIAGNOSTIC	SFI PURCHASED MAINT	22,273	22,987	4.03
4.04	0.00		SFI PURCHASED MAINT	0	0	4.04
4.05	57.00	CT SCAN	SFI PURCHASED MAINT	15,548	16,046	4.05
4.06	58.00	MRI	SFI PURCHASED MAINT	24,376	25,158	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	SFI PURCHASED SERVICES	53,237	54,944	4.07
4.08	56.00	RADIOISOTOPE	SFI PURCHASED SERVICES	22,664	23,391	4.08
4.09	57.00	CT SCAN	SFI PURCHASED SERVICES	128,795	132,924	4.09
4.10	60.00	LABORATORY	SYSTEMS LAB	701,395	701,395	4.10
4.11	31.00	INTENSIVE CARE UNIT	EICU	145,991	145,991	4.11
4.12	0.00		SFI PURCHASED MAINT	0	0	4.12
4.13	0.00		SFI PURCHASES SERVICES	0	0	4.13
4.14	57.00	CT SCAN	PET SCAN	137,105	131,685	4.14
4.15	0.00			0	0	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,811,658	8,643,648	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	OSF HEALTHCARE SYSTEM	100.00		0.00	6.00
7.00			0.00		0.00	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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2017 6:48 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	147,007	9		1.00
2.00	29,028	9		2.00
3.00	-177,705	0		3.00
3.01	-1,130,391	0		3.01
3.02	-29,758	0		3.02
4.00	0	0		4.00
4.01	-30,787	0		4.01
4.02	363,753	0		4.02
4.03	-714	0		4.03
4.04	0	0		4.04
4.05	-498	0		4.05
4.06	-782	0		4.06
4.07	-1,707	0		4.07
4.08	-727	0		4.08
4.09	-4,129	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	5,420	0		4.14
4.15	0	0		4.15
5.00	-831,990			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			6.00
7.00			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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2017 6:48 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	5.00	ADMINISTRATIVE & GENERAL	215,000	0	215,000	159,800	2,064	1.00
2.00	30.00	ADULTS & PEDIATRICS	12,819	11,500	1,319	150,200	11	2.00
3.00	53.00	ANESTHESIOLOGY	453,091	399,694	53,397	167,500	356	3.00
4.00	60.00	LABORATORY	15,617	15,617	0	208,000	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	10,000	2,308	7,692	159,800	320	5.00
6.00	76.97	CARDIAC REHABILITATION	6,000	0	6,000	159,800	60	6.00
7.00	91.00	EMERGENCY	1,923,052	1,890,552	32,500	159,800	183	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,635,579	2,319,671	315,908		2,994	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	158,571	7,929	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	794	40	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	28,668	1,433	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	24,585	1,229	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	4,610	231	0	0	0	6.00
7.00	91.00	EMERGENCY	14,059	703	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			231,287	11,565	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	5.00	ADMINISTRATIVE & GENERAL	0	158,571	56,429	56,429		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	794	525	12,025		2.00
3.00	53.00	ANESTHESIOLOGY	0	28,668	24,729	424,423		3.00
4.00	60.00	LABORATORY	0	0	0	15,617		4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	24,585	0	2,308		5.00
6.00	76.97	CARDIAC REHABILITATION	0	4,610	1,390	1,390		6.00
7.00	91.00	EMERGENCY	0	14,059	18,441	1,908,993		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	231,287	101,514	2,421,185		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/23/2017 6:48 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,848,565	1,848,565				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,890,201		1,890,201			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,807,372	0	550	5,807,922		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,565,351	527,018	1,142,820	572,818	8,808,007	5.00
6.00	00600	MAINTENANCE & REPAIRS	155,059	12,687	2,840	18,741	189,327	6.00
7.00	00700	OPERATION OF PLANT	1,581,906	105,750	90,781	141,436	1,919,873	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	155,112	25,245	0	7,016	187,373	8.00
9.00	00900	HOUSEKEEPING	519,430	31,370	14,162	153,460	718,422	9.00
10.00	01000	DIETARY	122,151	9,530	1,337	34,635	167,653	10.00
11.00	01100	CAFETERIA	313,763	38,014	4,131	108,447	464,355	11.00
13.00	01300	NURSING ADMINISTRATION	814,008	3,428	35,662	242,572	1,095,670	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	330,799	24,561	0	119,397	474,757	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,593,863	186,479	84,834	710,551	3,575,727	30.00
31.00	03100	INTENSIVE CARE UNIT	913,230	33,020	35,980	229,047	1,211,277	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,425,198	184,382	200,444	546,466	3,356,490	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	84,862	0	23,207	0	108,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	532,283	57,345	44,817	148,690	783,135	54.00
54.10	03630	ULTRA SOUND	252,180	3,393	4,671	67,793	328,037	54.10
54.20	03440	MAMMOGRAPHY	258,271	5,301	0	44,976	308,548	54.20
56.00	05600	RADIOISOTOPE	251,874	577	80,873	24,849	358,173	56.00
57.00	05700	CT SCAN	598,076	7,881	10,777	51,431	668,165	57.00
58.00	05800	MRI	515,442	3,616	0	53,741	572,799	58.00
60.00	06000	LABORATORY	2,056,197	7,846	17,166	277,634	2,358,843	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	180,670	0	0	0	180,670	63.00
65.00	06500	RESPIRATORY THERAPY	387,419	4,924	1,668	99,474	493,485	65.00
66.00	06600	PHYSICAL THERAPY	802,379	52,186	19,577	249,915	1,124,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	295,359	16,127	1,761	95,358	408,605	67.00
68.00	06800	SPEECH PATHOLOGY	306,744	24,184	9,304	70,842	411,074	68.00
69.00	06900	ELECTROCARDIOLOGY	244,737	2,733	7,895	68,727	324,092	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	305,877	0	12,561	69,148	387,586	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,006,953	23,383	4,587	39,735	1,074,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,191,712	0	5,758	0	1,197,470	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,142,527	11,992	0	199,542	2,354,061	73.00
76.00	03950	DIABETES SERVICES	65,380	1,213	0	20,676	87,269	76.00
76.97	07697	CARDIAC REHABILITATION	66,976	15,550	7,728	23,399	113,653	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,542,527	65,721	24,310	439,749	2,072,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,124,453	1,485,456	1,890,201	4,930,265	37,883,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,751	7,339	0	6,896	45,986	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,440,528	308,202	0	865,521	7,614,251	192.00
192.01	19201	CARDIAC PHASE III	0	259	0	0	259	192.01
192.02	19202	FUND DEVELOPMENT	398,993	25,068	0	2,234	426,295	192.02
192.03	19203	PULMONARY FUNCTION	9,447	0	0	3,006	12,453	192.03
193.00	19300	NONPAID WORKERS	0	22,241	0	0	22,241	193.00
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)	46,005,172	1,848,565	1,890,201	5,807,922	46,005,172	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/23/2017 6:48 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,808,007					5.00
6.00	00600	MAINTENANCE & REPAIRS	44,831	234,158				6.00
7.00	00700	OPERATION OF PLANT	454,611	18,919	2,393,403			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,368	4,516	50,220	286,477		8.00
9.00	00900	HOUSEKEEPING	170,117	5,612	62,406	0	956,557	9.00
10.00	01000	DIETARY	39,699	1,705	18,959	228	7,951	10.00
11.00	01100	CAFETERIA	109,956	6,801	75,624	704	31,717	11.00
13.00	01300	NURSING ADMINISTRATION	259,446	613	6,819	0	2,860	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,419	4,394	48,861	0	20,492	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	846,704	33,361	370,970	92,523	155,585	30.00
31.00	03100	INTENSIVE CARE UNIT	286,821	5,907	65,687	13,828	27,549	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	794,790	32,986	366,799	67,458	153,835	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	25,590	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	185,440	10,259	114,080	33,046	47,845	54.00
54.10	03630	ULTRA SOUND	77,677	607	6,749	0	2,831	54.10
54.20	03440	MAMMOGRAPHY	73,062	948	10,546	0	4,423	54.20
56.00	05600	RADIOISOTOPE	84,813	103	1,148	0	482	56.00
57.00	05700	CT SCAN	158,216	1,410	15,678	0	6,575	57.00
58.00	05800	MRI	135,634	647	7,194	0	3,017	58.00
60.00	06000	LABORATORY	558,555	1,404	15,607	0	6,546	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	42,781	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	116,853	881	9,796	0	4,108	65.00
66.00	06600	PHYSICAL THERAPY	266,168	9,336	103,815	7,003	43,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,754	2,885	32,082	0	13,455	67.00
68.00	06800	SPEECH PATHOLOGY	97,339	4,327	48,111	0	20,178	68.00
69.00	06900	ELECTROCARDIOLOGY	76,742	489	5,437	0	2,280	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91,777	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	254,470	4,183	46,518	0	19,510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	283,551	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	557,423	2,145	23,856	0	10,005	73.00
76.00	03950	DIABETES SERVICES	20,665	217	2,414	0	1,012	76.00
76.97	07697	CARDIAC REHABILITATION	26,912	2,782	30,934	0	12,974	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	490,706	11,758	130,742	70,078	54,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,884,890	169,195	1,671,052	284,868	653,603	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,889	1,313	14,600	0	6,123	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,803,009	55,140	613,121	1,609	257,144	192.00
192.01	19201	CARDIAC PHASE III	61	46	516	0	216	192.01
192.02	19202	FUND DEVELOPMENT	100,943	4,485	49,869	0	20,915	192.02
192.03	19203	PULMONARY FUNCTION	2,949	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	5,266	3,979	44,245	0	18,556	193.00
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)	8,808,007	234,158	2,393,403	286,477	956,557	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/23/2017 6:48 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	236,195					10.00
11.00	01100	CAFETERIA	0	689,157				11.00
13.00	01300	NURSING ADMINISTRATION	0	25,523	1,390,931			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,851	0	680,774		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	194,337	113,437	545,463	41,900	0	30.00
31.00	03100	INTENSIVE CARE UNIT	34,284	28,359	136,366	10,936	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,574	79,406	381,824	75,427	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,241	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,687	0	25,115	0	54.00
54.10	03630	ULTRA SOUND	0	8,508	0	16,136	0	54.10
54.20	03440	MAMMOGRAPHY	0	5,672	0	9,231	0	54.20
56.00	05600	RADIOISOTOPE	0	5,672	0	12,675	0	56.00
57.00	05700	CT SCAN	0	5,672	0	72,041	0	57.00
58.00	05800	MRI	0	8,508	0	33,501	0	58.00
60.00	06000	LABORATORY	0	53,882	0	124,894	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,958	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	17,016	0	8,370	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,577	0	12,632	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,378	0	8,036	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,763	0	3,047	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,344	0	20,785	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,344	0	10,014	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,508	0	30,184	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,938	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	17,016	0	66,491	0	73.00
76.00	03950	DIABETES SERVICES	0	2,836	13,637	611	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,836	0	2,053	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	65,226	313,641	53,558	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	236,195	570,021	1,390,931	680,774	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	0	119,136	0	0	0	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	0	0	0	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	236,195	689,157	1,390,931	680,774	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/23/2017 6:48 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,970,007	0	5,970,007		30.00
31.00	03100	INTENSIVE CARE UNIT	1,821,014	0	1,821,014		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,316,589	0	5,316,589		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	144,900	0	144,900		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,221,607	0	1,221,607		54.00
54.10	03630	ULTRA SOUND	440,545	0	440,545		54.10
54.20	03440	MAMMOGRAPHY	412,430	0	412,430		54.20
56.00	05600	RADIOISOTOPE	463,066	0	463,066		56.00
57.00	05700	CT SCAN	927,757	0	927,757		57.00
58.00	05800	MRI	761,300	0	761,300		58.00
60.00	06000	LABORATORY	3,119,731	0	3,119,731		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	226,409	0	226,409		63.00
65.00	06500	RESPIRATORY THERAPY	650,509	0	650,509		65.00
66.00	06600	PHYSICAL THERAPY	1,600,128	0	1,600,128		66.00
67.00	06700	OCCUPATIONAL THERAPY	576,195	0	576,195		67.00
68.00	06800	SPEECH PATHOLOGY	592,839	0	592,839		68.00
69.00	06900	ELECTROCARDIOLOGY	441,169	0	441,169		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	500,721	0	500,721		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,438,031	0	1,438,031		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,509,959	0	1,509,959		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,030,997	0	3,030,997		73.00
76.00	03950	DIABETES SERVICES	128,661	0	128,661		76.00
76.97	07697	CARDIAC REHABILITATION	192,144	0	192,144		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	3,262,849	0	3,262,849		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,749,557	0	34,749,557		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78,911	0	78,911		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,463,410	0	10,463,410		192.00
192.01	19201	CARDIAC PHASE III	1,098	0	1,098		192.01
192.02	19202	FUND DEVELOPMENT	602,507	0	602,507		192.02
192.03	19203	PULMONARY FUNCTION	15,402	0	15,402		192.03
193.00	19300	NONPAID WORKERS	94,287	0	94,287		193.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	46,005,172	0	46,005,172		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/23/2017 6:48 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	0	550	550	550	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	105,887	527,018	1,142,820	1,775,725	54	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	12,687	2,840	15,527	2	6.00
7.00	00700	OPERATION OF PLANT	0	105,750	90,781	196,531	13	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,245	0	25,245	1	8.00
9.00	00900	HOUSEKEEPING	0	31,370	14,162	45,532	14	9.00
10.00	01000	DIETARY	0	9,530	1,337	10,867	3	10.00
11.00	01100	CAFETERIA	0	38,014	4,131	42,145	10	11.00
13.00	01300	NURSING ADMINISTRATION	3,000	3,428	35,662	42,090	23	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,730	24,561	0	26,291	11	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,063	186,479	84,834	273,376	67	30.00
31.00	03100	INTENSIVE CARE UNIT	0	33,020	35,980	69,000	21	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,386	184,382	200,444	460,212	51	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	23,207	23,207	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,345	44,817	102,162	14	54.00
54.10	03630	ULTRA SOUND	0	3,393	4,671	8,064	6	54.10
54.20	03440	MAMMOGRAPHY	76,814	5,301	0	82,115	4	54.20
56.00	05600	RADIOISOTOPE	0	577	80,873	81,450	2	56.00
57.00	05700	CT SCAN	93,000	7,881	10,777	111,658	5	57.00
58.00	05800	MRI	257,218	3,616	0	260,834	5	58.00
60.00	06000	LABORATORY	111,007	7,846	17,166	136,019	26	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,762	4,924	1,668	10,354	9	65.00
66.00	06600	PHYSICAL THERAPY	0	52,186	19,577	71,763	23	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,127	1,761	17,888	9	67.00
68.00	06800	SPEECH PATHOLOGY	0	24,184	9,304	33,488	7	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,733	7,895	10,628	6	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61,447	0	12,561	74,008	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	978	23,383	4,587	28,948	4	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,758	5,758	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,654	11,992	0	67,646	19	73.00
76.00	03950	DIABETES SERVICES	0	1,213	0	1,213	2	76.00
76.97	07697	CARDIAC REHABILITATION	0	15,550	7,728	23,278	2	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,948	65,721	24,310	93,979	41	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	851,894	1,485,456	1,890,201	4,227,551	460	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,339	0	7,339	1	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	150,988	308,202	0	459,190	89	192.00
192.01	19201	CARDIAC PHASE III	0	259	0	259	0	192.01
192.02	19202	FUND DEVELOPMENT	0	25,068	0	25,068	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	22,241	0	22,241	0	193.00
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)	1,002,882	1,848,565	1,890,201	4,741,648	550	202.00

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		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,775,779					5.00
6.00	00600	MAINTENANCE & REPAIRS	9,038	24,567				6.00
7.00	00700	OPERATION OF PLANT	91,655	1,985	290,184			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,945	474	6,089	40,754		8.00
9.00	00900	HOUSEKEEPING	34,297	589	7,566	0	87,998	9.00
10.00	01000	DIETARY	8,004	179	2,299	32	731	10.00
11.00	01100	CAFETERIA	22,168	714	9,169	100	2,918	11.00
13.00	01300	NURSING ADMINISTRATION	52,307	64	827	0	263	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,665	461	5,924	0	1,885	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	170,705	3,500	44,978	13,164	14,313	30.00
31.00	03100	INTENSIVE CARE UNIT	57,826	620	7,964	1,967	2,534	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	160,239	3,461	44,472	9,596	14,152	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	5,159	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,387	1,076	13,831	4,701	4,401	54.00
54.10	03630	ULTRA SOUND	15,660	64	818	0	260	54.10
54.20	03440	MAMMOGRAPHY	14,730	99	1,279	0	407	54.20
56.00	05600	RADIOISOTOPE	17,099	11	139	0	44	56.00
57.00	05700	CT SCAN	31,898	148	1,901	0	605	57.00
58.00	05800	MRI	27,345	68	872	0	278	58.00
60.00	06000	LABORATORY	112,611	147	1,892	0	602	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,625	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	23,559	92	1,188	0	378	65.00
66.00	06600	PHYSICAL THERAPY	53,662	980	12,587	996	4,005	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,507	303	3,890	0	1,238	67.00
68.00	06800	SPEECH PATHOLOGY	19,625	454	5,833	0	1,856	68.00
69.00	06900	ELECTROCARDIOLOGY	15,472	51	659	0	210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,503	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	51,304	439	5,640	0	1,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	57,167	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	112,383	225	2,892	0	920	73.00
76.00	03950	DIABETES SERVICES	4,166	23	293	0	93	76.00
76.97	07697	CARDIAC REHABILITATION	5,426	292	3,751	0	1,193	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	98,932	1,234	15,852	9,969	5,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,388,069	17,753	202,605	40,525	60,125	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,195	138	1,770	0	563	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	363,495	5,783	74,336	229	23,659	192.00
192.01	19201	CARDIAC PHASE III	12	5	63	0	20	192.01
192.02	19202	FUND DEVELOPMENT	20,351	471	6,046	0	1,924	192.02
192.03	19203	PULMONARY FUNCTION	595	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	1,062	417	5,364	0	1,707	193.00
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)	1,775,779	24,567	290,184	40,754	87,998	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	22,115					10.00
11.00	01100	CAFETERIA	0	77,224				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,860	98,434			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,224	0	59,461		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,196	12,711	38,602	3,664	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,210	3,178	9,650	956	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	709	8,898	27,021	6,595	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	983	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,542	0	2,196	0	54.00
54.10	03630	ULTRA SOUND	0	953	0	1,411	0	54.10
54.20	03440	MAMMOGRAPHY	0	636	0	807	0	54.20
56.00	05600	RADIOISOTOPE	0	636	0	1,108	0	56.00
57.00	05700	CT SCAN	0	636	0	6,299	0	57.00
58.00	05800	MRI	0	953	0	2,929	0	58.00
60.00	06000	LABORATORY	0	6,038	0	10,857	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	259	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,907	0	732	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,763	0	1,104	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,611	0	703	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	982	0	266	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,271	0	1,817	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,271	0	876	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	953	0	2,639	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,530	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,907	0	5,814	0	73.00
76.00	03950	DIABETES SERVICES	0	318	965	53	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	318	0	180	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	7,309	22,196	4,683	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,115	63,875	98,434	59,461	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	0	13,349	0	0	0	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	0	0	0	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	22,115	77,224	98,434	59,461	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/23/2017 6:48 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	593,276	0	593,276		30.00
31.00	03100	INTENSIVE CARE UNIT	156,926	0	156,926		31.00
43.00	04300	NURSERY	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	735,406	0	735,406		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	29,349	0	29,349		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,310	0	168,310		54.00
54.10	03630	ULTRA SOUND	27,236	0	27,236		54.10
54.20	03440	MAMMOGRAPHY	100,077	0	100,077		54.20
56.00	05600	RADIOISOTOPE	100,489	0	100,489		56.00
57.00	05700	CT SCAN	153,150	0	153,150		57.00
58.00	05800	MRI	293,284	0	293,284		58.00
60.00	06000	LABORATORY	268,192	0	268,192		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,884	0	8,884		63.00
65.00	06500	RESPIRATORY THERAPY	38,219	0	38,219		65.00
66.00	06600	PHYSICAL THERAPY	148,883	0	148,883		66.00
67.00	06700	OCCUPATIONAL THERAPY	45,149	0	45,149		67.00
68.00	06800	SPEECH PATHOLOGY	62,511	0	62,511		68.00
69.00	06900	ELECTROCARDIOLOGY	30,114	0	30,114		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94,664	0	94,664		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,722	0	91,722		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,455	0	65,455		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,806	0	191,806		73.00
76.00	03950	DIABETES SERVICES	7,126	0	7,126		76.00
76.97	07697	CARDIAC REHABILITATION	34,440	0	34,440		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	259,239	0	259,239		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,703,907	0	3,703,907		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,006	0	12,006		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	940,130	0	940,130		192.00
192.01	19201	CARDIAC PHASE III	359	0	359		192.01
192.02	19202	FUND DEVELOPMENT	53,860	0	53,860		192.02
192.03	19203	PULMONARY FUNCTION	595	0	595		192.03
193.00	19300	NONPAID WORKERS	30,791	0	30,791		193.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,741,648	0	4,741,648		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 6:48 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	156,923					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,845,141				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	537	18,124,521			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	44,738	1,115,575	1,787,566	-8,808,007	37,197,165	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,077	2,772	58,483	0	189,327	6.00
7.00	00700	OPERATION OF PLANT	8,977	88,617	441,371	0	1,919,873	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,143	0	21,895	0	187,373	8.00
9.00	00900	HOUSEKEEPING	2,663	13,824	478,894	0	718,422	9.00
10.00	01000	DIETARY	809	1,305	108,083	0	167,653	10.00
11.00	01100	CAFETERIA	3,227	4,033	338,424	0	464,355	11.00
13.00	01300	NURSING ADMINISTRATION	291	34,812	756,982	0	1,095,670	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,085	0	372,595	0	474,757	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,830	82,812	2,217,382	0	3,575,727	30.00
31.00	03100	INTENSIVE CARE UNIT	2,803	35,122	714,775	0	1,211,277	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,652	195,666	1,705,328	0	3,356,490	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	22,654	0	0	108,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,868	43,749	464,008	0	783,135	54.00
54.10	03630	ULTRA SOUND	288	4,560	211,557	0	328,037	54.10
54.20	03440	MAMMOGRAPHY	450	0	140,353	0	308,548	54.20
56.00	05600	RADIOISOTOPE	49	78,945	77,544	0	358,173	56.00
57.00	05700	CT SCAN	669	10,520	160,498	0	668,165	57.00
58.00	05800	MRI	307	0	167,707	0	572,799	58.00
60.00	06000	LABORATORY	666	16,757	866,399	0	2,358,843	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	180,670	63.00
65.00	06500	RESPIRATORY THERAPY	418	1,628	310,425	0	493,485	65.00
66.00	06600	PHYSICAL THERAPY	4,430	19,110	779,896	0	1,124,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,369	1,719	297,578	0	408,605	67.00
68.00	06800	SPEECH PATHOLOGY	2,053	9,082	221,072	0	411,074	68.00
69.00	06900	ELECTROCARDIOLOGY	232	7,707	214,473	0	324,092	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,262	215,788	0	387,586	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,985	4,478	123,999	0	1,074,658	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,621	0	0	1,197,470	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,018	0	622,701	0	2,354,061	73.00
76.00	03950	DIABETES SERVICES	103	0	64,523	0	87,269	76.00
76.97	07697	CARDIAC REHABILITATION	1,320	7,544	73,021	0	113,653	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,579	23,730	1,372,302	0	2,072,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	126,099	1,845,141	15,385,622	-8,808,007	29,075,680	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	623	0	21,521	0	45,986	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,163	0	2,701,025	0	7,614,251	192.00
192.01	19201	CARDIAC PHASE III	22	0	0	0	259	192.01
192.02	19202	FUND DEVELOPMENT	2,128	0	6,972	0	426,295	192.02
192.03	19203	PULMONARY FUNCTION	0	0	9,381	0	12,453	192.03
193.00	19300	NONPAID WORKERS	1,888	0	0	0	22,241	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,848,565	1,890,201	5,807,922		8,808,007	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.780077	1.024421	0.320446		0.236792	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			550		1,775,779	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000030		0.047740	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/23/2017 6:48 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	111,108					6.00
7.00	00700	OPERATION OF PLANT	8,977	102,131				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,143	2,143	227,499			8.00
9.00	00900	HOUSEKEEPING	2,663	2,663	0	97,325		9.00
10.00	01000	DIETARY	809	809	181	809	17,058	10.00
11.00	01100	CAFETERIA	3,227	3,227	559	3,227	0	11.00
13.00	01300	NURSING ADMINISTRATION	291	291	0	291	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,085	2,085	0	2,085	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,830	15,830	73,475	15,830	14,035	30.00
31.00	03100	INTENSIVE CARE UNIT	2,803	2,803	10,981	2,803	2,476	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,652	15,652	53,570	15,652	547	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,868	4,868	26,243	4,868	0	54.00
54.10	03630	ULTRA SOUND	288	288	0	288	0	54.10
54.20	03440	MAMMOGRAPHY	450	450	0	450	0	54.20
56.00	05600	RADIOISOTOPE	49	49	0	49	0	56.00
57.00	05700	CT SCAN	669	669	0	669	0	57.00
58.00	05800	MRI	307	307	0	307	0	58.00
60.00	06000	LABORATORY	666	666	0	666	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	418	418	0	418	0	65.00
66.00	06600	PHYSICAL THERAPY	4,430	4,430	5,561	4,430	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,369	1,369	0	1,369	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,053	2,053	0	2,053	0	68.00
69.00	06900	ELECTROCARDIOLOGY	232	232	0	232	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,985	1,985	0	1,985	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	1,018	1,018	0	1,018	0	73.00
76.00	03950	DIABETES SERVICES	103	103	0	103	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,320	1,320	0	1,320	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,579	5,579	55,651	5,579	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	80,284	71,307	226,221	66,501	17,058	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	623	623	0	623	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,163	26,163	1,278	26,163	0	192.00
192.01	19201	CARDIAC PHASE III	22	22	0	22	0	192.01
192.02	19202	FUND DEVELOPMENT	2,128	2,128	0	2,128	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	1,888	1,888	0	1,888	0	193.00
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)	234,158	2,393,403	286,477	956,557	236,195	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.107481	23.434638	1.259245	9.828482	13.846582	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,567	290,184	40,754	87,998	22,115	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.221109	2.841292	0.179139	0.904166	1.296459	205.00

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		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)	SOCIAL SERVICE (PATIENT DAYS)		
			11.00	13.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	24,301					11.00
13.00	01300	NURSING ADMINISTRATION	900	10,200				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	700	0	188,381,158			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,000	4,000	11,593,719	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,000	1,000	3,026,145	0		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,800	2,800	20,870,734	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	3,110,497	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800	0	6,949,458	0		54.00
54.10	03630	ULTRA SOUND	300	0	4,464,804	0		54.10
54.20	03440	MAMMOGRAPHY	200	0	2,554,107	0		54.20
56.00	05600	RADIOISOTOPE	200	0	3,507,123	0		56.00
57.00	05700	CT SCAN	200	0	19,933,779	0		57.00
58.00	05800	MRI	300	0	9,269,735	0		58.00
60.00	06000	LABORATORY	1,900	0	34,568,407	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	818,433	0		63.00
65.00	06500	RESPIRATORY THERAPY	600	0	2,316,063	0		65.00
66.00	06600	PHYSICAL THERAPY	1,184	0	3,495,249	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	507	0	2,223,456	0		67.00
68.00	06800	SPEECH PATHOLOGY	309	0	843,043	0		68.00
69.00	06900	ELECTROCARDIOLOGY	400	0	5,751,281	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	400	0	2,770,868	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	300	0	8,352,015	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,007,159	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	600	0	18,398,278	0		73.00
76.00	03950	DIABETES SERVICES	100	100	169,048	0		76.00
76.97	07697	CARDIAC REHABILITATION	100	0	568,055	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,300	2,300	14,819,702	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,100	10,200	188,381,158	0		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,201	0	0	0		192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0		192.01
192.02	19202	FUND DEVELOPMENT	0	0	0	0		192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
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)	689,157	1,390,931	680,774	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.359203	136.365784	0.003614	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,224	98,434	59,461	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.177812	9.650392	0.000316	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 6:48 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,970,007		5,970,007	525	5,970,532	30.00
31.00	03100	INTENSIVE CARE UNIT	1,821,014		1,821,014	0	1,821,014	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,316,589		5,316,589	0	5,316,589	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	144,900		144,900	24,729	169,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,221,607		1,221,607	0	1,221,607	54.00
54.10	03630	ULTRA SOUND	440,545		440,545	0	440,545	54.10
54.20	03440	MAMMOGRAPHY	412,430		412,430	0	412,430	54.20
56.00	05600	RADIOISOTOPE	463,066		463,066	0	463,066	56.00
57.00	05700	CT SCAN	927,757		927,757	0	927,757	57.00
58.00	05800	MRI	761,300		761,300	0	761,300	58.00
60.00	06000	LABORATORY	3,119,731		3,119,731	0	3,119,731	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	226,409		226,409	0	226,409	63.00
65.00	06500	RESPIRATORY THERAPY	650,509	0	650,509	0	650,509	65.00
66.00	06600	PHYSICAL THERAPY	1,600,128	0	1,600,128	0	1,600,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	576,195	0	576,195	0	576,195	67.00
68.00	06800	SPEECH PATHOLOGY	592,839	0	592,839	0	592,839	68.00
69.00	06900	ELECTROCARDIOLOGY	441,169		441,169	0	441,169	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	500,721		500,721	0	500,721	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,438,031		1,438,031	0	1,438,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,509,959		1,509,959	0	1,509,959	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,030,997		3,030,997	0	3,030,997	73.00
76.00	03950	DIABETES SERVICES	128,661		128,661	0	128,661	76.00
76.97	07697	CARDIAC REHABILITATION	192,144		192,144	1,390	193,534	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,262,849		3,262,849	18,441	3,281,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,000,265		1,000,265		1,000,265	92.00
200.00		Subtotal (see instructions)	35,749,822	0	35,749,822	45,085	35,794,907	200.00
201.00		Less Observation Beds	1,000,265		1,000,265		1,000,265	201.00
202.00		Total (see instructions)	34,749,557	0	34,749,557	45,085	34,794,642	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 6:48 pm

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		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	9,489,635		9,489,635			30.00
31.00	03100	INTENSIVE CARE UNIT	2,766,943		2,766,943			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,409,868	15,460,866	20,870,734	0.254739	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	770,325	2,340,172	3,110,497	0.046584	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	845,428	6,104,030	6,949,458	0.175785	0.000000	54.00
54.10	03630	ULTRA SOUND	265,506	4,199,298	4,464,804	0.098671	0.000000	54.10
54.20	03440	MAMMOGRAPHY	1,977	2,552,130	2,554,107	0.161477	0.000000	54.20
56.00	05600	RADIOISOTOPE	238,248	3,268,875	3,507,123	0.132036	0.000000	56.00
57.00	05700	CT SCAN	2,466,850	17,466,929	19,933,779	0.046542	0.000000	57.00
58.00	05800	MRI	531,834	8,737,901	9,269,735	0.082127	0.000000	58.00
60.00	06000	LABORATORY	6,840,780	27,727,627	34,568,407	0.090248	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	305,110	513,323	818,433	0.276637	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,319,441	996,622	2,316,063	0.280868	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	470,417	3,024,832	3,495,249	0.457801	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	449,447	1,774,009	2,223,456	0.259144	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	73,617	769,426	843,043	0.703213	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	978,158	4,773,123	5,751,281	0.076708	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,050	2,764,818	2,770,868	0.180709	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,650,030	4,701,985	8,352,015	0.172178	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,705,971	2,301,188	8,007,159	0.188576	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,814,855	11,583,423	18,398,278	0.164744	0.000000	73.00
76.00	03950	DIABETES SERVICES	1,026	168,022	169,048	0.761092	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	568,055	568,055	0.338249	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,098,335	12,721,367	14,819,702	0.220170	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	379,807	1,983,479	2,363,286	0.423252	0.000000	92.00
200.00		Subtotal (see instructions)	51,879,658	136,501,500	188,381,158			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	51,879,658	136,501,500	188,381,158			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 6:48 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.254739		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.054534		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175785		54.00
54.10	03630	ULTRA SOUND	0.098671		54.10
54.20	03440	MAMMOGRAPHY	0.161477		54.20
56.00	05600	RADIOISOTOPE	0.132036		56.00
57.00	05700	CT SCAN	0.046542		57.00
58.00	05800	MRI	0.082127		58.00
60.00	06000	LABORATORY	0.090248		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.276637		63.00
65.00	06500	RESPIRATORY THERAPY	0.280868		65.00
66.00	06600	PHYSICAL THERAPY	0.457801		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.259144		67.00
68.00	06800	SPEECH PATHOLOGY	0.703213		68.00
69.00	06900	ELECTROCARDIOLOGY	0.076708		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.180709		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.172178		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.188576		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.164744		73.00
76.00	03950	DIABETES SERVICES	0.761092		76.00
76.97	07697	CARDIAC REHABILITATION	0.340696		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.221414		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.423252		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,970,007		5,970,007	525	5,970,532	30.00
31.00	03100	INTENSIVE CARE UNIT	1,821,014		1,821,014	0	1,821,014	31.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,316,589		5,316,589	0	5,316,589	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	144,900		144,900	24,729	169,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,221,607		1,221,607	0	1,221,607	54.00
54.10	03630	ULTRA SOUND	440,545		440,545	0	440,545	54.10
54.20	03440	MAMMOGRAPHY	412,430		412,430	0	412,430	54.20
56.00	05600	RADIOISOTOPE	463,066		463,066	0	463,066	56.00
57.00	05700	CT SCAN	927,757		927,757	0	927,757	57.00
58.00	05800	MRI	761,300		761,300	0	761,300	58.00
60.00	06000	LABORATORY	3,119,731		3,119,731	0	3,119,731	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	226,409		226,409	0	226,409	63.00
65.00	06500	RESPIRATORY THERAPY	650,509	0	650,509	0	650,509	65.00
66.00	06600	PHYSICAL THERAPY	1,600,128	0	1,600,128	0	1,600,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	576,195	0	576,195	0	576,195	67.00
68.00	06800	SPEECH PATHOLOGY	592,839	0	592,839	0	592,839	68.00
69.00	06900	ELECTROCARDIOLOGY	441,169		441,169	0	441,169	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	500,721		500,721	0	500,721	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,438,031		1,438,031	0	1,438,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,509,959		1,509,959	0	1,509,959	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,030,997		3,030,997	0	3,030,997	73.00
76.00	03950	DIABETES SERVICES	128,661		128,661	0	128,661	76.00
76.97	07697	CARDIAC REHABILITATION	192,144		192,144	1,390	193,534	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,262,849		3,262,849	18,441	3,281,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,000,265		1,000,265		1,000,265	92.00
200.00		Subtotal (see instructions)	35,749,822	0	35,749,822	45,085	35,794,907	200.00
201.00		Less Observation Beds	1,000,265		1,000,265		1,000,265	201.00
202.00		Total (see instructions)	34,749,557	0	34,749,557	45,085	34,794,642	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

		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	9,489,635		9,489,635			30.00
31.00	03100	INTENSIVE CARE UNIT	2,766,943		2,766,943			31.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,409,868	15,460,866	20,870,734	0.254739	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	770,325	2,340,172	3,110,497	0.046584	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	845,428	6,104,030	6,949,458	0.175785	0.000000	54.00
54.10	03630	ULTRA SOUND	265,506	4,199,298	4,464,804	0.098671	0.000000	54.10
54.20	03440	MAMMOGRAPHY	1,977	2,552,130	2,554,107	0.161477	0.000000	54.20
56.00	05600	RADIOISOTOPE	238,248	3,268,875	3,507,123	0.132036	0.000000	56.00
57.00	05700	CT SCAN	2,466,850	17,466,929	19,933,779	0.046542	0.000000	57.00
58.00	05800	MRI	531,834	8,737,901	9,269,735	0.082127	0.000000	58.00
60.00	06000	LABORATORY	6,840,780	27,727,627	34,568,407	0.090248	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	305,110	513,323	818,433	0.276637	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	1,319,441	996,622	2,316,063	0.280868	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	470,417	3,024,832	3,495,249	0.457801	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	449,447	1,774,009	2,223,456	0.259144	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	73,617	769,426	843,043	0.703213	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	978,158	4,773,123	5,751,281	0.076708	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,050	2,764,818	2,770,868	0.180709	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,650,030	4,701,985	8,352,015	0.172178	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,705,971	2,301,188	8,007,159	0.188576	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,814,855	11,583,423	18,398,278	0.164744	0.000000	73.00
76.00	03950	DIABETES SERVICES	1,026	168,022	169,048	0.761092	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	568,055	568,055	0.338249	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,098,335	12,721,367	14,819,702	0.220170	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	379,807	1,983,479	2,363,286	0.423252	0.000000	92.00
200.00		Subtotal (see instructions)	51,879,658	136,501,500	188,381,158			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	51,879,658	136,501,500	188,381,158			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.10	03630	ULTRA SOUND	0.000000		54.10
54.20	03440	MAMMOGRAPHY	0.000000		54.20
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	DIABETES SERVICES	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I | Date/Time Prepared: 2/23/2017 6:48 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	593,276	0	593,276	4,996	118.75	30.00
31.00	INTENSIVE CARE UNIT	156,926		156,926	1,009	155.53	31.00
43.00	NURSERY	0		0	400	0.00	43.00
200.00	Total (lines 30-199)	750,202		750,202	6,405		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	2,586	307,088				30.00
31.00	INTENSIVE CARE UNIT	472	73,410				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	3,058	380,498				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/23/2017 6:48 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	735,406	20,870,734	0.035236	1,968,028	69,345	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	29,349	3,110,497	0.009435	280,836	2,650	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,310	6,949,458	0.024219	522,498	12,654	54.00
54.10	03630	ULTRA SOUND	27,236	4,464,804	0.006100	132,881	811	54.10
54.20	03440	MAMMOGRAPHY	100,077	2,554,107	0.039183	531	21	54.20
56.00	05600	RADIOISOTOPE	100,489	3,507,123	0.028653	134,524	3,855	56.00
57.00	05700	CT SCAN	153,150	19,933,779	0.007683	1,363,156	10,473	57.00
58.00	05800	MRI	293,284	9,269,735	0.031639	352,032	11,138	58.00
60.00	06000	LABORATORY	268,192	34,568,407	0.007758	4,126,665	32,015	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,884	818,433	0.010855	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	38,219	2,316,063	0.016502	884,772	14,601	65.00
66.00	06600	PHYSICAL THERAPY	148,883	3,495,249	0.042596	231,401	9,857	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,149	2,223,456	0.020306	223,115	4,531	67.00
68.00	06800	SPEECH PATHOLOGY	62,511	843,043	0.074149	54,590	4,048	68.00
69.00	06900	ELECTROCARDIOLOGY	30,114	5,751,281	0.005236	638,920	3,345	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94,664	2,770,868	0.034164	6,050	207	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,722	8,352,015	0.010982	1,994,398	21,902	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,455	8,007,159	0.008175	2,693,851	22,022	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,806	18,398,278	0.010425	3,626,840	37,810	73.00
76.00	03950	DIABETES SERVICES	7,126	169,048	0.042154	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	34,440	568,055	0.060628	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	259,239	14,819,702	0.017493	1,273,847	22,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	99,393	2,363,286	0.042057	191,959	8,073	92.00
200.00		Total (lines 50-199)	3,053,098	176,124,580		20,700,894	291,641	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/23/2017 6:48 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
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	4,996	0.00	2,586	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,009	0.00	472	0		31.00
43.00	04300	NURSERY	400	0.00	0	0		43.00
200.00		Total (lines 30-199)	6,405		3,058	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 6:48 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.10	03630	ULTRA SOUND	0	0	0	0	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	DIABETES SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/23/2017 6:48 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	20,870,734	0.000000	0.000000	1,968,028	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	3,110,497	0.000000	0.000000	280,836	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,949,458	0.000000	0.000000	522,498	54.00
54.10	03630	ULTRA SOUND	0	4,464,804	0.000000	0.000000	132,881	54.10
54.20	03440	MAMMOGRAPHY	0	2,554,107	0.000000	0.000000	531	54.20
56.00	05600	RADIOISOTOPE	0	3,507,123	0.000000	0.000000	134,524	56.00
57.00	05700	CT SCAN	0	19,933,779	0.000000	0.000000	1,363,156	57.00
58.00	05800	MRI	0	9,269,735	0.000000	0.000000	352,032	58.00
60.00	06000	LABORATORY	0	34,568,407	0.000000	0.000000	4,126,665	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	818,433	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,316,063	0.000000	0.000000	884,772	65.00
66.00	06600	PHYSICAL THERAPY	0	3,495,249	0.000000	0.000000	231,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,223,456	0.000000	0.000000	223,115	67.00
68.00	06800	SPEECH PATHOLOGY	0	843,043	0.000000	0.000000	54,590	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,751,281	0.000000	0.000000	638,920	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,770,868	0.000000	0.000000	6,050	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,352,015	0.000000	0.000000	1,994,398	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,007,159	0.000000	0.000000	2,693,851	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,398,278	0.000000	0.000000	3,626,840	73.00
76.00	03950	DIABETES SERVICES	0	169,048	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	568,055	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,819,702	0.000000	0.000000	1,273,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,363,286	0.000000	0.000000	191,959	92.00
200.00		Total (lines 50-199)	0	176,124,580			20,700,894	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/23/2017 6:48 pm

Title XVIII | Hospital | 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	1,711,650	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	240,262	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	827,679	0		54.00
54.10	03630	ULTRA SOUND	0	435,415	0		54.10
54.20	03440	MAMMOGRAPHY	0	0	0		54.20
56.00	05600	RADIOISOTOPE	0	686,145	0		56.00
57.00	05700	CT SCAN	0	5,380,705	0		57.00
58.00	05800	MRI	0	1,118,850	0		58.00
60.00	06000	LABORATORY	0	1,947,695	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	194,353	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,624	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,048	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	36,302	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	926,020	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	408,204	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	548,874	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	258,700	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	555,051	0		73.00
76.00	03950	DIABETES SERVICES	0	1,396	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	148,824	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	1,709,097	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	289,209	0		92.00
200.00		Total (lines 50-199)	0	17,428,103	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/23/2017 6:48 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	0.254739	1,711,650	0	0	436,024	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.046584	240,262	0	0	11,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175785	827,679	0	0	145,494	54.00
54.10	03630	ULTRA SOUND	0.098671	435,415	0	0	42,963	54.10
54.20	03440	MAMMOGRAPHY	0.161477	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0.132036	686,145	0	0	90,596	56.00
57.00	05700	CT SCAN	0.046542	5,380,705	0	0	250,429	57.00
58.00	05800	MRI	0.082127	1,118,850	0	0	91,888	58.00
60.00	06000	LABORATORY	0.090248	1,947,695	0	0	175,776	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.276637	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.280868	194,353	0	0	54,588	65.00
66.00	06600	PHYSICAL THERAPY	0.457801	1,624	0	0	743	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.259144	2,048	0	0	531	67.00
68.00	06800	SPEECH PATHOLOGY	0.703213	36,302	0	0	25,528	68.00
69.00	06900	ELECTROCARDIOLOGY	0.076708	926,020	0	0	71,033	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.180709	408,204	0	0	73,766	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.172178	548,874	0	0	94,504	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.188576	258,700	142	0	48,785	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.164744	555,051	492	125,648	91,441	73.00
76.00	03950	DIABETES SERVICES	0.761092	1,396	0	0	1,062	76.00
76.97	07697	CARDIAC REHABILITATION	0.338249	148,824	0	0	50,340	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.220170	1,709,097	0	0	376,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.423252	289,209	0	0	122,408	92.00
200.00		Subtotal (see instructions)		17,428,103	634	125,648	2,255,383	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		17,428,103	634	125,648	2,255,383	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/23/2017 6:48 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
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.10	03630	ULTRA SOUND	0	0		54.10
54.20	03440	MAMMOGRAPHY	0	0		54.20
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81	20,700		73.00
76.00	03950	DIABETES SERVICES	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
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)	108	20,700		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	108	20,700		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

	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	593,276	0	593,276	4,996	118.75	30.00
31.00	INTENSIVE CARE UNIT	156,926		156,926	1,009	155.53	31.00
43.00	NURSERY	0		0	400	0.00	43.00
200.00	Total (lines 30-199)	750,202		750,202	6,405		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	200	23,750				30.00
31.00	INTENSIVE CARE UNIT	53	8,243				31.00
43.00	NURSERY	21	0				43.00
200.00	Total (lines 30-199)	274	31,993				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

		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	735,406	20,870,734	0.035236	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	29,349	3,110,497	0.009435	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,310	6,949,458	0.024219	0	0	54.00
54.10	03630	ULTRA SOUND	27,236	4,464,804	0.006100	0	0	54.10
54.20	03440	MAMMOGRAPHY	100,077	2,554,107	0.039183	0	0	54.20
56.00	05600	RADIOISOTOPE	100,489	3,507,123	0.028653	0	0	56.00
57.00	05700	CT SCAN	153,150	19,933,779	0.007683	0	0	57.00
58.00	05800	MRI	293,284	9,269,735	0.031639	0	0	58.00
60.00	06000	LABORATORY	268,192	34,568,407	0.007758	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,884	818,433	0.010855	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	38,219	2,316,063	0.016502	0	0	65.00
66.00	06600	PHYSICAL THERAPY	148,883	3,495,249	0.042596	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,149	2,223,456	0.020306	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	62,511	843,043	0.074149	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,114	5,751,281	0.005236	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94,664	2,770,868	0.034164	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,722	8,352,015	0.010982	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,455	8,007,159	0.008175	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,806	18,398,278	0.010425	0	0	73.00
76.00	03950	DIABETES SERVICES	7,126	169,048	0.042154	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	34,440	568,055	0.060628	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	259,239	14,819,702	0.017493	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,363,286	0.000000	0	0	92.00
200.00		Total (lines 50-199)	2,953,705	176,124,580		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

		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
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	4,996	0.00	200	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,009	0.00	53	0		31.00
43.00	04300	NURSERY	400	0.00	21	0		43.00
200.00		Total (lines 30-199)	6,405		274	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.10	03630	ULTRA SOUND	0	0	0	0	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00	03950	DIABETES SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
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: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

		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	20,870,734	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	3,110,497	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,949,458	0.000000	0.000000	0	54.00
54.10	03630	ULTRA SOUND	0	4,464,804	0.000000	0.000000	0	54.10
54.20	03440	MAMMOGRAPHY	0	2,554,107	0.000000	0.000000	0	54.20
56.00	05600	RADIOISOTOPE	0	3,507,123	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	19,933,779	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	9,269,735	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	34,568,407	0.000000	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	818,433	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,316,063	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,495,249	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,223,456	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	843,043	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,751,281	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,770,868	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,352,015	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,007,159	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	18,398,278	0.000000	0.000000	0	73.00
76.00	03950	DIABETES SERVICES	0	169,048	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	568,055	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	14,819,702	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,363,286	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	176,124,580			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/23/2017 6:48 pm

Title XIX | Hospital | Cost

		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
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.10	03630	ULTRA SOUND	0	0	0		54.10
54.20	03440	MAMMOGRAPHY	0	0	0		54.20
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	DIABETES SERVICES	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 6:48 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)	5,329	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,996	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)	4,159	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)	333	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)	2,586	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)	215	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)	5,970,532	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)	5,970,532	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)	5,970,532	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)	1,195.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,090,425	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)	3,090,425	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 6:48 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	1,821,014	1,009	1,804.77	472	851,851	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)	3,417,165	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,359,441	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)	380,498	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	291,641	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	672,139	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,687,302	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)	837	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,195.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,000,265	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/23/2017 6:48 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	593,276	5,970,532	0.099367	1,000,265	99,393	90.00
91.00	Nursing School cost	0	5,970,532	0.000000	1,000,265	0	91.00
92.00	Allied health cost	0	5,970,532	0.000000	1,000,265	0	92.00
93.00	All other Medical Education	0	5,970,532	0.000000	1,000,265	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/23/2017 6:48 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		3,909,671		30.00
31.00	03100	INTENSIVE CARE UNIT		1,444,792		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.254739	1,968,028	501,333	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.054534	280,836	15,315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175785	522,498	91,847	54.00
54.10	03630	ULTRA SOUND	0.098671	132,881	13,112	54.10
54.20	03440	MAMMOGRAPHY	0.161477	531	86	54.20
56.00	05600	RADIOISOTOPE	0.132036	134,524	17,762	56.00
57.00	05700	CT SCAN	0.046542	1,363,156	63,444	57.00
58.00	05800	MRI	0.082127	352,032	28,911	58.00
60.00	06000	LABORATORY	0.090248	4,126,665	372,423	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.276637	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.280868	884,772	248,504	65.00
66.00	06600	PHYSICAL THERAPY	0.457801	231,401	105,936	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.259144	223,115	57,819	67.00
68.00	06800	SPEECH PATHOLOGY	0.703213	54,590	38,388	68.00
69.00	06900	ELECTROCARDIOLOGY	0.076708	638,920	49,010	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.180709	6,050	1,093	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.172178	1,994,398	343,391	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.188576	2,693,851	507,996	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.164744	3,626,840	597,500	73.00
76.00	03950	DIABETES SERVICES	0.761092	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.340696	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.221414	1,273,847	282,048	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.423252	191,959	81,247	92.00
200.00		Total (sum of lines 50-94 and 96-98)		20,700,894	3,417,165	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)		20,700,894		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3

Component CCN: 14-U161 | Date/Time Prepared: 2/23/2017 6:48 pm

Title XVIII | Swing Beds - SNF | 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	0.254739	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.046584	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175785	2,304	405	54.00
54.10	03630	ULTRA SOUND	0.098671	1,886	186	54.10
54.20	03440	MAMMOGRAPHY	0.161477	0	0	54.20
56.00	05600	RADIOISOTOPE	0.132036	0	0	56.00
57.00	05700	CT SCAN	0.046542	0	0	57.00
58.00	05800	MRI	0.082127	0	0	58.00
60.00	06000	LABORATORY	0.090248	45,594	4,115	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.276637	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.280868	8,807	2,474	65.00
66.00	06600	PHYSICAL THERAPY	0.457801	53,824	24,641	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.259144	54,047	14,006	67.00
68.00	06800	SPEECH PATHOLOGY	0.703213	562	395	68.00
69.00	06900	ELECTROCARDIOLOGY	0.076708	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.180709	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.172178	17,913	3,084	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.188576	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.164744	56,256	9,268	73.00
76.00	03950	DIABETES SERVICES	0.761092	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.338249	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.220170	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.423252	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		241,193	58,574	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)		241,193		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/23/2017 6:48 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)	6,207,140	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)	13,464	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	1,466,383	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	38.80	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.03	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17.14	31.00
32.00	Sum of lines 30 and 31	19.17	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.21	33.00
34.00	Disproportionate share adjustment (see instructions)	80,848	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/23/2017 6:48 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	0.000033464	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	214,375	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	214,375	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	214,375		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)	6,515,827		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	8,159,788		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		8,159,788	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		500,090	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)		8,659,878	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,659,878	61.00
62.00	Deductibles billed to program beneficiaries		820,400	62.00
63.00	Coinsurance billed to program beneficiaries		4,186	63.00
64.00	Allowable bad debts (see instructions)		179,282	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		116,533	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		33,710	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,951,825	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)		81,581	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/23/2017 6:48 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	1,486,096	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,519,502	71.00
71.01	Sequestration adjustment (see instructions)		190,390	71.01
72.00	Interim payments		9,292,551	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)		36,561	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		395,913	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: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/23/2017 6:48 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	20,808	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,255,383	2.00
3.00	PPS payments	4,829,328	3.00
4.00	Outlier payment (see instructions)	2,439	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)	20,808	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	126,282	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)	126,282	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)	126,282	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	105,474	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)	20,808	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)	4,831,767	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	76	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,058,725	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)	3,793,774	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)	3,793,774	30.00
31.00	Primary payer payments	70	31.00
32.00	Subtotal (line 30 minus line 31)	3,793,704	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)	226,290	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	147,089	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,940	36.00
37.00	Subtotal (see instructions)	3,940,793	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER PS&R ADJUSTMENT	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)	3,940,793	40.00
40.01	Sequestration adjustment (see instructions)	78,816	40.01
41.00	Interim payments	3,838,735	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	23,242	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 2/23/2017 6:48 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		9,292,551		3,838,735	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)		9,292,551		3,838,735	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		36,561		23,242	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,329,112		3,861,977	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: 14-0161 | Component CCN: 14-U161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2017 6:48 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		53,585		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		53,585		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		53,585		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-0161 | Component CCN: 14-U161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-2 | Date/Time Prepared: 2/23/2017 6:48 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	57,710	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	215	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	57,710	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	57,710	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	57,710	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,031	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	54,679	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	54,679	0	19.00
19.01	Sequestration adjustment (see instructions)	1,094	0	19.01
20.00	Interim payments	53,585	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

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

Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/23/2017 6:48 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	699,593	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	33,855,604	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,660,719	0	0	0	6.00
7.00	Inventory	751,856	0	0	0	7.00
8.00	Prepaid expenses	11,536	0	0	0	8.00
9.00	Other current assets	1,077,563	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)	12,735,433	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	600,013	0	0	0	12.00
13.00	Land improvements	2,390,475	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,137,419	0	0	0	15.00
16.00	Accumulated depreciation	-22,315,568	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-2,181,362	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,134,143	0	0	0	23.00
24.00	Accumulated depreciation	-17,377,871	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	134,215	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,521,464	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	31,959,120	457,511	855,212	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	12,021	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	31,971,141	457,511	855,212	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,228,038	457,511	855,212	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,358,066	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,236	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	0	0	0	0	43.00
44.00	Other current liabilities	5,004,061	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,370,363	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	69,709	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	69,709	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,440,072	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	61,787,966				52.00
53.00	Specific purpose fund		457,511			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			855,212		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)	61,787,966	457,511	855,212	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,228,038	457,511	855,212	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/23/2017 6:48 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		54,751,666		626,581		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,479,696				2.00
3.00	Total (sum of line 1 and line 2)		70,231,362		626,581		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	INCREASE IN RESTRICTED ASSETS	0		98,101		3,503	5.00
6.00	CONTRIBUTIONS TEMP RESTRICTED	0		93,941		0	6.00
7.00	EQUITY TRANSFER	12,759		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)		12,759		192,042		10.00
11.00	Subtotal (line 3 plus line 10)		70,244,121		818,623		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	DECREASE IN RESTRICTED ASSETS	0		361,112		0	13.00
14.00	EQUITY TRANSFER	8,456,155		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)		8,456,155		361,112		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		61,787,966		457,511		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	851,709		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)	851,709		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	INCREASE IN RESTRICTED ASSETS		0			5.00
6.00	CONTRIBUTIONS TEMP RESTRICTED		0			6.00
7.00	EQUITY TRANSFER		0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	3,503		0		10.00
11.00	Subtotal (line 3 plus line 10)	855,212		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	DECREASE IN RESTRICTED ASSETS		0			13.00
14.00	EQUITY TRANSFER		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)	855,212		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2017 6:48 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,489,635		9,489,635	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,489,635		9,489,635	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,766,943		2,766,943	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)	2,766,943		2,766,943	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,256,578		12,256,578	17.00
18.00	Ancillary services	39,622,054	135,765,423	175,387,477	18.00
19.00	Outpatient services	1,026	736,077	737,103	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	1,173,401	17,655,736	18,829,137	27.00
27.01	OTHER NRCC	0	359,662	359,662	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	53,053,059	154,516,898	207,569,957	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,398,764		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)		51,398,764		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet G-3 Date/Time Prepared: 2/23/2017 6:48 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	207,569,957	1.00
2.00	Less contractual allowances and discounts on patients' accounts	143,074,509	2.00
3.00	Net patient revenues (line 1 minus line 2)	64,495,448	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,398,764	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,096,684	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	446,736	6.00
7.00	Income from investments	1,604,574	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	144,604	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	483,468	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	11,349	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	-257,630	24.00
24.01	RENTAL OF PHYSICIAN OFFICES	54,759	24.01
25.00	Total other income (sum of lines 6-24)	2,487,860	25.00
26.00	Total (line 5 plus line 25)	15,584,544	26.00
27.00	OTHER EXPENSES	104,848	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	104,848	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,479,696	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0161	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 2/23/2017 6:48 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	497,891	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,199	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)	14.26	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)	500,090	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