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

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141306	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/21/2016 8:34 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2016 Time: 8:34 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 COMMUNITY MEMORIAL HOSPITAL (141306) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 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	7,970	-330	-9,024	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	84,713	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	92,683	-330	-9,024	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2016 8:34 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 CALDWELL STREET	PO Box:			1.00
2.00	City: STAUNTON	State: IL	Zip Code: 62088-1499	County: MACOUPIN	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	COMMUNITY MEMORIAL HOSPITAL	141306	99914	1	08/01/2000	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	COMMUNITY MEMORIAL HOSPITAL- SWB	14Z306	99914		08/01/2000	N	O	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3		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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 8:34 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	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)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		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.	Y	Y	Y	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	112,339	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2016 8:34 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	219,234	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: 141306	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 8:34 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)	07/01/2015	09/30/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2016 8:34 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/28/2016	Y	09/28/2016
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2016 8:34 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					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.	BRIAN		ENGELKE		41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY MEMORIAL HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(618) 635-4242		BENGELKE@STAUNTONHOSPITAL.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141306	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/21/2016 8:34 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.	CFO		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: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 8:34 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	25	9,150	14,068.00	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)		25	9,150	14,068.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	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						13.00
14.00	Total (see instructions)		25	9,150	14,068.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 8:34 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)	386	46	593			1.00
2.00	HMO and other (see instructions)	63	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	335	0	335			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	135			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	721	46	1,063			7.00
8.00	INTENSIVE CARE UNIT	0	0	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						13.00
14.00	Total (see instructions)	721	46	1,063	0.00	106.28	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	106.28	27.00
28.00	Observation Bed Days		13	85			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	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 8:34 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	154	24	237	1.00
2.00	HMO and other (see instructions)			0	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	154	24	237	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/21/2016 8:34 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)	0.485649	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,970,000	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	503,035	5.00
6.00	Medicaid charges	6,536,120	6.00
7.00	Medicaid cost (line 1 times line 6)	3,174,260	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)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (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 , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	31,048	0	31,048	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	15,078	0	15,078	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	15,078	0	15,078	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,429,586	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	114,465	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,315,121	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	638,687	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	653,765	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	653,765	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/21/2016 8:34 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		1,117,970	1,117,970	-1,022,568	95,402	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1		0	0	4,649	4,649	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2		0	0	671,168	671,168	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	501,400	501,400	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	3,399	3,399	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	61,639	1,179,324	1,240,963	42,560	1,283,523	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	576,803	1,388,615	1,965,418	-93,071	1,872,347	5.01
5.02	00550	DATA PROCESSING	155,760	22,468	178,228	0	178,228	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	168,382	10,997	179,379	0	179,379	5.03
7.00	00700	OPERATION OF PLANT	186,546	480,132	666,678	829	667,507	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,006	44,849	48,855	0	48,855	8.00
9.00	00900	HOUSEKEEPING	175,280	32,775	208,055	0	208,055	9.00
10.00	01000	DIETARY	115,136	92,110	207,246	-92,495	114,751	10.00
11.00	01100	CAFETERIA	0	0	0	92,495	92,495	11.00
13.00	01300	NURSING ADMINISTRATION	223,501	15,539	239,040	0	239,040	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144,227	43,600	187,827	0	187,827	16.00
17.00	01700	SOCIAL SERVICE	60,713	507	61,220	0	61,220	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	193,100	193,100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	954,578	154,588	1,109,166	-92,576	1,016,590	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	173,478	34,893	208,371	0	208,371	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	197,646	197,646	-193,100	4,546	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,234	569,323	996,557	0	996,557	54.00
60.00	06000	LABORATORY	470,755	412,532	883,287	0	883,287	60.00
64.00	06400	INTRAVENOUS THERAPY	0	7,683	7,683	92,576	100,259	64.00
65.00	06500	RESPIRATORY THERAPY	211,063	162,095	373,158	-25,331	347,827	65.00
66.00	06600	PHYSICAL THERAPY	49,666	655,413	705,079	9,565	714,644	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	54,045	54,045	0	54,045	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,677	10,677	0	10,677	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,562	100,777	189,339	25,331	214,670	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,242	1,224,651	1,437,893	0	1,437,893	73.00
76.00	03050	CARDIAC REHAB	62,570	2,985	65,555	0	65,555	76.00
76.01	03030	BEHAVIORAL HEALTH	131,156	127,539	258,695	0	258,695	76.01
76.02	03040	WOUND CARE	0	219,000	219,000	0	219,000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	643,094	187,902	830,996	0	830,996	90.00
91.00	09100	EMERGENCY	514,161	1,574,123	2,088,284	0	2,088,284	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		117,052	117,052	-117,052	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,811,552	10,241,810	16,053,362	879	16,054,241	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	879	879	-879	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	5,811,552	10,242,689	16,054,241	0	16,054,241	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/21/2016 8:34 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	0	95,402		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	4,649		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	671,168		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-259,860	241,540		2.00
3.00	00300	OTHER CAP REL COSTS	-3,399	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-82,741	1,200,782		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-275,602	1,596,745		5.01
5.02	00550	DATA PROCESSING	0	178,228		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	179,379		5.03
7.00	00700	OPERATION OF PLANT	0	667,507		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,855		8.00
9.00	00900	HOUSEKEEPING	0	208,055		9.00
10.00	01000	DIETARY	-945	113,806		10.00
11.00	01100	CAFETERIA	-31,923	60,572		11.00
13.00	01300	NURSING ADMINISTRATION	-1,435	237,605		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,536	181,291		16.00
17.00	01700	SOCIAL SERVICE	0	61,220		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	193,100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,016,590		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	208,371		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	4,546		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-585	995,972		54.00
60.00	06000	LABORATORY	-29,768	853,519		60.00
64.00	06400	INTRAVENOUS THERAPY	0	100,259		64.00
65.00	06500	RESPIRATORY THERAPY	-16,008	331,819		65.00
66.00	06600	PHYSICAL THERAPY	0	714,644		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	54,045		67.00
68.00	06800	SPEECH PATHOLOGY	0	10,677		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,081	212,589		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,765	1,433,128		73.00
76.00	03050	CARDIAC REHAB	-2,445	63,110		76.00
76.01	03030	BEHAVIORAL HEALTH	0	258,695		76.01
76.02	03040	WOUND CARE	0	219,000		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-362,895	468,101		90.00
91.00	09100	EMERGENCY	-523,128	1,565,156		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,604,116	14,450,125		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MOB	0	0		194.00
194.01	07951	MOB	0	0		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-1,604,116	14,450,125		200.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/21/2016 8:34 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	3,300		1.00
2.00	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	649,638		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	363,235		3.00
4.00	OPERATION OF PLANT	7.00	0	829		4.00
5.00	PHYSICAL THERAPY	66.00	0	9,565		5.00
	0		0	1,026,567		
	B - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42,560		1.00
	0		0	42,560		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	117,052		1.00
	0		0	117,052		
	D - EQUIPMENTAL RENTAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,451		1.00
	0		0	14,451		
	E - CAFETERIA EXPENSE					
1.00	CAFETERIA	11.00	51,386	41,109		1.00
	0		51,386	41,109		
	F - OXYGEN EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	25,331		1.00
	0		0	25,331		
	G - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	33,540		1.00
	0		0	33,540		
	H - ADVERTISING					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	879		1.00
	0		0	879		
	J - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	193,100		1.00
	0		0	193,100		
	K - PROPERTY TAX					
1.00	OTHER CAP REL COSTS	3.00	0	3,399		1.00
	0		0	3,399		
	L - OBSERVATION IV THERAPY					
1.00	INTRAVENOUS THERAPY	64.00	92,576	0		1.00
	TOTALS		92,576	0		
500.00	Grand Total: Increases		143,962	1,497,988		500.00

RECLASSIFICATIONS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/21/2016 8:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,026,567	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		0	1,026,567			
	B - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42,560	0		1.00
	0		0	42,560			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	117,052	11		1.00
	0		0	117,052			
	D - EQUIPMENTAL RENTAL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	14,451	10		1.00
	0		0	14,451			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	51,386	41,109	0		1.00
	0		51,386	41,109			
	F - OXYGEN EXPENSE						
1.00	RESPIRATORY THERAPY	65.00	0	25,331	0		1.00
	0		0	25,331			
	G - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33,540	0		1.00
	0		0	33,540			
	H - ADVERTISING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	879	12		1.00
	0		0	879			
	J - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	193,100	0		1.00
	0		0	193,100			
	K - PROPERTY TAX						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	3,399	0		1.00
	0		0	3,399			
	L - OBSERVATION IV THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	92,576	0	0		1.00
	TOTALS		92,576	0			
500.00	Grand Total: Decreases		143,962	1,497,988			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2016 8:34 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	532,386	14,100	0	14,100	0	1.00
2.00	Land Improvements	527,547	1,897,117	0	1,897,117	116,824	2.00
3.00	Buildings and Fixtures	3,502,795	5,643,851	0	5,643,851	654,394	3.00
4.00	Building Improvements	2,005,590	6,489,586	0	6,489,586	657,763	4.00
5.00	Fixed Equipment	152,478	23,595	0	23,595	0	5.00
6.00	Movable Equipment	15,796,762	-11,321,022	0	-11,321,022	342,721	6.00
7.00	HIT designated Assets	497,365	219,234	0	219,234	0	7.00
8.00	Subtotal (sum of lines 1-7)	23,014,923	2,966,461	0	2,966,461	1,771,702	8.00
9.00	Reconciling Items	11,578,066	-11,578,066	0	-11,578,066	0	9.00
10.00	Total (line 8 minus line 9)	11,436,857	14,544,527	0	14,544,527	1,771,702	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	546,486	0	1.00
2.00	Land Improvements	2,307,840	0	2.00
3.00	Buildings and Fixtures	8,492,252	0	3.00
4.00	Building Improvements	7,837,413	0	4.00
5.00	Fixed Equipment	176,073	0	5.00
6.00	Movable Equipment	4,133,019	0	6.00
7.00	HIT designated Assets	716,599	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,209,682	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,209,682	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/21/2016 8:34 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	1,117,970	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,117,970	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	1,117,970	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,117,970	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III | Date/Time Prepared: 11/21/2016 8:34 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,854,325	0	2,854,325	0.119232	3,999	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	962,895	0	962,895	0.040222	1,349	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	15,366,770	0	15,366,770	0.641905	21,530	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	5,025,691	270,362	4,755,329	0.198641	6,662	2.00
3.00	Total (sum of lines 1-2)	24,209,681	270,362	23,939,319	1.000000	33,540	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	3,999	91,403	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	0	1,349	3,300	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	21,530	649,638	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,662	220,427	14,451	2.00
3.00	Total (sum of lines 1-2)	0	0	33,540	964,768	14,451	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	3,999	0	0	95,402	1.00
1.01	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	1,349	0	0	4,649	1.01
1.02	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	21,530	0	0	671,168	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,662	0	0	241,540	2.00
3.00	Total (sum of lines 1-2)	0	33,540	0	0	1,012,759	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/21/2016 8:34 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
1.01	Investment income - CAP REL COSTS-BLDG & FIXT- BLDG 1 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	1.01
1.02	Investment income - CAP REL COSTS-BLDG & FIXT- BLDG 2 (chapter 2)		0	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-117,052	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-19,183	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-2,026	CLINIC	90.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,588	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,843	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-929,773			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,923	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	B	-2,081	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-4,765	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,536	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT- BLDG 1		0	CAP REL COSTS-BLDG & FIXT-BLDG 1	1.01	0	26.01
26.02	Depreciation - CAP REL COSTS-BLDG & FIXT- BLDG 2		0	CAP REL COSTS-BLDG & FIXT-BLDG 2	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/21/2016 8:34 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	
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	A	-142,808	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	IHA LOBBYING FEES	A	-6,290	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	TAXES	A	-3,399	OTHER CAP REL COSTS	3.00	13	33.01
33.02	MEDICAID PROVIDER TAX	A	-224,840	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.02
33.04	MISCELLANEOUS OPERATING REVENUE	B	-102	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.04
33.05	X-RAY FILM COPYING	B	-585	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.06	INSERVICE EDUCATION	B	-1,435	NURSING ADMINISTRATION	13.00	0	33.06
33.07	CARDIAC REHAB	B	-2,445	CARDIAC REHAB	76.00	0	33.07
33.08	DIABETIC CONSULTATION	B	-945	DIETARY	10.00	0	33.08
33.09	PUBLIC RELATIONS SALARIES	A	-13,695	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.09
33.10	PUBLIC REATIONS OTHER	A	-2,182	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.10
33.11	PUBLIC RELATIONS BENEFITS	A	-3,025	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PHYSICIAN ADVERTISING EXPENSE	A	-879	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.12
33.13	PHYSICIAN BENEFITS	A	-79,716	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,604,116				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2016 8:34 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	30.00	ADULTS & PEDIATRICS	34,000	0	34,000	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	16,008	16,008	0	0	0	2.00
3.00	90.00	CLINIC	360,869	360,869	0	0	0	3.00
4.00	91.00	EMERGENCY	1,452,537	523,128	929,409	0	0	4.00
5.00	76.01	BEHAVIORAL HEALTH	29,375	0	29,375	0	0	5.00
6.00	60.00	LABORATORY	81,776	29,768	52,008	0	0	6.00
7.00	0.00		0	0	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			1,974,565	929,773	1,044,792		0	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	76.01	BEHAVIORAL HEALTH	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	0.00		0	0	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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	16,008		2.00
3.00	90.00	CLINIC	0	0	0	360,869		3.00
4.00	91.00	EMERGENCY	0	0	0	523,128		4.00
5.00	76.01	BEHAVIORAL HEALTH	0	0	0	0		5.00
6.00	60.00	LABORATORY	0	0	0	29,768		6.00
7.00	0.00		0	0	0	0		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	0	0	929,773		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 8:34 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					255	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,252.00	1,739.00	4,860.50	564.00	0.00	9.00
10.00	AHSEA (see instructions)	106.91	79.20	59.40	39.60	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.60	39.60	29.70			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					240,761	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					137,729	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					288,714	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					667,204	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					22,334	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					689,538	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					689,538	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					10,098	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,098	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,594	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,692	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					11,692	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 8:34 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.20	59.40	39.60	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	689,538		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	11,692		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	701,230		63.00
64.00	Total cost of outside supplier services (from your records)	607,040		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	10,098		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,594		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	11,692		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,594		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	1,594		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 8:34 pm

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	109	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	131	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	6.25	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	153.00	563.34	0.00	0.00	9.00
10.00	AHSEA (see instructions)	101.34	75.07	56.30	37.54	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.54	37.54	28.15			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	11,486	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	31,716	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	43,202	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	43,202	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	60.31	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	47,042	22.00
23.00	Total salary equivalency (see instructions)	47,042	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	4,092	24.00
25.00	Assistants (line 4 times column 3, line 11)	3,688	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	7,780	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,500	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	9,280	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	9,280	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 8:34 pm

		Occupational Therapy	Cost	
		1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0		45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0		46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.07	56.30	37.54	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	47,042	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	9,280	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	56,322	63.00
64.00	Total cost of outside supplier services (from your records)	54,045	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,780	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,500	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	9,280	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,500	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	1,500	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 8:34 pm

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					68	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					6.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	151.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	97.39	72.14	54.10	36.07	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.07	36.07	27.05			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					10,929	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					10,929	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					10,929	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					72.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					56,269	22.00
23.00	Total salary equivalency (see instructions)					56,269	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					2,453	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,453	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					425	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,878	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,878	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/21/2016 8:34 pm

		Speech Pathology	Cost	
		1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0		46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.14	54.10	36.07	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	56,269	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,878	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	59,147	63.00
64.00	Total cost of outside supplier services (from your records)	10,677	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	2,453	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	425	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,878	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	425	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	425	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIXT- BLDG 1	BLDG & FIXT- BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	95,402	95,402				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	4,649	0	4,649			1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	671,168	0	0	671,168		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	241,540				241,540	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,200,782	118	0	860	300	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,596,745	6,412	1,444	39,402	16,313	5.01
5.02	00550	DATA PROCESSING	178,228	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	179,379	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	667,507	31,564	1,354	222,986	80,309	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,855	1,214	261	7,523	3,088	8.00
9.00	00900	HOUSEKEEPING	208,055	804	86	5,418	2,045	9.00
10.00	01000	DIETARY	113,806	2,208	0	16,080	5,619	10.00
11.00	01100	CAFETERIA	60,572	1,780	0	12,960	4,529	11.00
13.00	01300	NURSING ADMINISTRATION	237,605	346	0	2,521	881	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	181,291	1,460	29	10,488	3,716	16.00
17.00	01700	SOCIAL SERVICE	61,220	138	0	1,004	351	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	193,100	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,016,590	10,212	0	74,352	25,982	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	208,371	5,298	0	38,572	13,479	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,546	109	0	792	277	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	995,972	4,071	0	29,638	10,357	54.00
60.00	06000	LABORATORY	853,519	3,313	341	22,405	8,430	60.00
64.00	06400	INTRAVENOUS THERAPY	100,259	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	331,819	1,101	0	8,016	2,801	65.00
66.00	06600	PHYSICAL THERAPY	714,644	4,441	0	32,333	11,299	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,045	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,677	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	212,589	2,267	297	15,008	5,767	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,433,128	1,048	0	7,629	2,666	73.00
76.00	03050	CARDIAC REHAB	63,110	1,393	0	10,140	3,543	76.00
76.01	03030	BEHAVIORAL HEALTH	258,695	541	544	1,198	1,377	76.01
76.02	03040	WOUND CARE	219,000	203	293	0	516	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	468,101	7,295	0	53,116	18,561	90.00
91.00	09100	EMERGENCY	1,565,156	2,870	0	20,899	7,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,450,125	90,206	4,649	633,340	229,509	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	467	0	3,399	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,729	0	34,429	12,031	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,450,125	95,402	4,649	671,168	241,540	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	Subtotal	DATA PROCESSING	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,202,060					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	118,003	1,778,319	1,778,319			5.01
5.02	00550	DATA PROCESSING	32,640	210,868	29,593	240,461	240,461	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	35,285	214,664	30,125	244,789	4,142	5.03
7.00	00700	OPERATION OF PLANT	39,092	1,042,812	146,345	1,189,157	20,123	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	839	61,780	8,670	70,450	1,192	8.00
9.00	00900	HOUSEKEEPING	36,731	253,139	35,525	288,664	4,885	9.00
10.00	01000	DIETARY	13,359	151,072	21,201	172,273	2,915	10.00
11.00	01100	CAFETERIA	10,768	90,609	12,716	103,325	1,748	11.00
13.00	01300	NURSING ADMINISTRATION	46,836	288,189	40,444	328,633	5,561	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,224	227,208	31,886	259,094	4,384	16.00
17.00	01700	SOCIAL SERVICE	12,723	75,436	10,586	86,022	1,456	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	193,100	27,099	220,199	3,726	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	180,638	1,307,774	183,529	1,491,303	25,236	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,353	302,073	42,392	344,465	5,829	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	5,724	803	6,527	110	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,529	1,129,567	158,520	1,288,087	21,797	54.00
60.00	06000	LABORATORY	98,650	986,658	138,465	1,125,123	19,039	60.00
64.00	06400	INTRAVENOUS THERAPY	19,400	119,659	16,793	136,452	2,309	64.00
65.00	06500	RESPIRATORY THERAPY	44,230	387,967	54,446	442,413	7,487	65.00
66.00	06600	PHYSICAL THERAPY	10,408	773,125	108,498	881,623	14,919	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	54,045	7,585	61,630	1,043	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,677	1,498	12,175	206	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,559	254,487	35,714	290,201	4,911	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,686	1,489,157	208,984	1,698,141	28,736	73.00
76.00	03050	CARDIAC REHAB	13,112	91,298	12,812	104,110	1,762	76.00
76.01	03030	BEHAVIORAL HEALTH	27,485	289,840	40,675	330,515	5,593	76.01
76.02	03040	WOUND CARE	0	220,012	30,876	250,888	4,246	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	134,764	681,837	95,687	777,524	13,157	90.00
91.00	09100	EMERGENCY	107,746	1,703,974	239,125	1,943,099	32,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,202,060	14,395,070	1,770,592	14,387,343	239,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,866	543	4,409	75	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51,189	7,184	58,373	988	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,202,060	14,450,125	1,778,319	14,450,125	240,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	BILLING, COLLECTION, & ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.03	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	248,931					5.03
7.00	00700	OPERATION OF PLANT	0	1,209,280				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,610	97,252			8.00
9.00	00900	HOUSEKEEPING	0	16,962	0	310,511		9.00
10.00	01000	DIETARY	0	46,602	0	13,689	235,479	10.00
11.00	01100	CAFETERIA	0	37,562	0	11,034	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,305	0	2,146	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,816	0	9,052	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,911	0	855	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,883	215,492	97,252	63,299	235,479	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,846	111,789	0	32,838	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,523	2,295	0	674	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,593	85,899	0	25,233	0	54.00
60.00	06000	LABORATORY	60,035	69,917	0	20,538	0	60.00
64.00	06400	INTRAVENOUS THERAPY	6,908	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,609	23,231	0	6,824	0	65.00
66.00	06600	PHYSICAL THERAPY	25,666	93,708	0	27,526	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,398	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	138	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,261	47,834	0	14,051	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,318	22,112	0	6,495	0	73.00
76.00	03050	CARDIAC REHAB	848	29,389	0	8,633	0	76.00
76.01	03030	BEHAVIORAL HEALTH	4,560	11,420	0	3,354	0	76.01
76.02	03040	WOUND CARE	3,341	4,282	0	1,258	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	153,941	0	45,220	0	90.00
91.00	09100	EMERGENCY	22,004	60,569	0	17,792	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	248,931	1,099,646	97,252	310,511	235,479	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,852	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	99,782	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	248,931	1,209,280	97,252	310,511	235,479	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
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	153,669					11.00
13.00	01300	NURSING ADMINISTRATION	7,863	351,508				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,074	0	308,420			16.00
17.00	01700	SOCIAL SERVICE	2,136	0	0	93,380		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	223,925	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,324	171,878	8,527	93,380	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,103	34,590	3,525	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	1,886	0	223,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,031	0	83,767	0	0	54.00
60.00	06000	LABORATORY	16,562	0	74,376	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	3,257	0	8,558	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,425	0	18,099	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,747	0	31,797	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,732	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	170	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,116	0	2,801	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,502	42,519	35,083	0	0	73.00
76.00	03050	CARDIAC REHAB	2,201	0	1,051	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	4,614	0	5,649	0	0	76.01
76.02	03040	WOUND CARE	0	0	4,139	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,625	0	0	0	0	90.00
91.00	09100	EMERGENCY	18,089	102,521	27,260	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	153,669	351,508	308,420	93,380	223,925	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	0	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	153,669	351,508	308,420	93,380	223,925	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/21/2016 8:34 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
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING					5.03
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
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,439,053	0	2,439,053		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	541,985	0	541,985		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	236,940	0	236,940		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,587,407	0	1,587,407		54.00
60.00	06000	LABORATORY	1,385,590	0	1,385,590		60.00
64.00	06400	INTRAVENOUS THERAPY	157,484	0	157,484		64.00
65.00	06500	RESPIRATORY THERAPY	520,088	0	520,088		65.00
66.00	06600	PHYSICAL THERAPY	1,076,986	0	1,076,986		66.00
67.00	06700	OCCUPATIONAL THERAPY	65,803	0	65,803		67.00
68.00	06800	SPEECH PATHOLOGY	12,689	0	12,689		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	365,175	0	365,175		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,868,906	0	1,868,906		73.00
76.00	03050	CARDIAC REHAB	147,994	0	147,994		76.00
76.01	03030	BEHAVIORAL HEALTH	365,705	0	365,705		76.01
76.02	03040	WOUND CARE	268,154	0	268,154		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,012,467	0	1,012,467		90.00
91.00	09100	EMERGENCY	2,224,220	0	2,224,220		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,276,646	0	14,276,646		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,336	0	14,336		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,143	0	159,143		192.00
194.00	07950	MOB	0	0	0		194.00
194.01	07951	MOB	0	0	0		194.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	14,450,125	0	14,450,125		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	BLDG & FIXT- BLDG 1	BLDG & FIXT- BLDG 2	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	118	0	860	300	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	6,412	1,444	39,402	16,313	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	31,564	1,354	222,986	80,309	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,214	261	7,523	3,088	8.00
9.00	00900	HOUSEKEEPING	0	804	86	5,418	2,045	9.00
10.00	01000	DIETARY	0	2,208	0	16,080	5,619	10.00
11.00	01100	CAFETERIA	0	1,780	0	12,960	4,529	11.00
13.00	01300	NURSING ADMINISTRATION	0	346	0	2,521	881	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,460	29	10,488	3,716	16.00
17.00	01700	SOCIAL SERVICE	0	138	0	1,004	351	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	10,212	0	74,352	25,982	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,298	0	38,572	13,479	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	109	0	792	277	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,071	0	29,638	10,357	54.00
60.00	06000	LABORATORY	0	3,313	341	22,405	8,430	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,101	0	8,016	2,801	65.00
66.00	06600	PHYSICAL THERAPY	0	4,441	0	32,333	11,299	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,267	297	15,008	5,767	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,048	0	7,629	2,666	73.00
76.00	03050	CARDIAC REHAB	0	1,393	0	10,140	3,543	76.00
76.01	03030	BEHAVIORAL HEALTH	0	541	544	1,198	1,377	76.01
76.02	03040	WOUND CARE	0	203	293	0	516	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,295	0	53,116	18,561	90.00
91.00	09100	EMERGENCY	0	2,870	0	20,899	7,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	90,206	4,649	633,340	229,509	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	467	0	3,399	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,729	0	34,429	12,031	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	95,402	4,649	671,168	241,540	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	OTHER ADMINISTRATIVE AND GENERAL	DATA PROCESSING	BILLING, COLLECTION, & ADMITTING	
			2A	4.00	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,278	1,278				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	63,571	126	63,697			5.01
5.02	00550	DATA PROCESSING	0	35	1,060	1,095		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	38	1,079	19	1,136	5.03
7.00	00700	OPERATION OF PLANT	336,213	42	5,242	92	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,086	1	311	5	0	8.00
9.00	00900	HOUSEKEEPING	8,353	39	1,273	22	0	9.00
10.00	01000	DIETARY	23,907	14	759	13	0	10.00
11.00	01100	CAFETERIA	19,269	11	455	8	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,748	50	1,449	25	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,693	32	1,142	20	0	16.00
17.00	01700	SOCIAL SERVICE	1,493	14	379	7	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	971	17	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,546	189	6,574	115	31	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,349	39	1,519	27	13	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1,178	0	29	1	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,066	95	5,678	99	316	54.00
60.00	06000	LABORATORY	34,489	105	4,960	87	271	60.00
64.00	06400	INTRAVENOUS THERAPY	0	21	602	11	31	64.00
65.00	06500	RESPIRATORY THERAPY	11,918	47	1,950	34	66	65.00
66.00	06600	PHYSICAL THERAPY	48,073	11	3,886	68	116	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	272	5	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	54	1	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,339	20	1,279	22	10	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,343	48	7,486	131	128	73.00
76.00	03050	CARDIAC REHAB	15,076	14	459	8	4	76.00
76.01	03030	BEHAVIORAL HEALTH	3,660	29	1,457	25	21	76.01
76.02	03040	WOUND CARE	1,012	0	1,106	19	15	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	78,972	143	3,428	60	0	90.00
91.00	09100	EMERGENCY	31,072	115	8,562	150	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	957,704	1,278	63,421	1,091	1,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,866	0	19	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,189	0	257	4	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,012,759	1,278	63,697	1,095	1,136	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	341,589					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,234	19,637				8.00
9.00	00900	HOUSEKEEPING	4,791	0	14,478			9.00
10.00	01000	DIETARY	13,164	0	638	38,495		10.00
11.00	01100	CAFETERIA	10,610	0	514	0	30,867	11.00
13.00	01300	NURSING ADMINISTRATION	2,064	0	100	0	1,579	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,705	0	422	0	1,019	16.00
17.00	01700	SOCIAL SERVICE	822	0	40	0	429	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	60,869	19,637	2,952	38,495	6,090	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,578	0	1,531	0	1,226	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	648	0	31	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,264	0	1,177	0	3,019	54.00
60.00	06000	LABORATORY	19,750	0	958	0	3,327	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	654	64.00
65.00	06500	RESPIRATORY THERAPY	6,562	0	318	0	1,492	65.00
66.00	06600	PHYSICAL THERAPY	26,470	0	1,283	0	351	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,512	0	655	0	626	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,246	0	303	0	1,507	73.00
76.00	03050	CARDIAC REHAB	8,302	0	403	0	442	76.00
76.01	03030	BEHAVIORAL HEALTH	3,226	0	156	0	927	76.01
76.02	03040	WOUND CARE	1,210	0	59	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	43,484	0	2,108	0	4,545	90.00
91.00	09100	EMERGENCY	17,109	0	830	0	3,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,620	19,637	14,478	38,495	30,867	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,783	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,186	0	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	341,589	19,637	14,478	38,495	30,867	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
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	9,015					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,033				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,184			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	988		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,408	747	3,184		253,837	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	887	309	0		94,478	50.00
51.00	05100	RECOVERY ROOM	0	0	0		0	51.00
53.00	05300	ANESTHESIOLOGY	0	165	0		2,059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,350	0		86,064	54.00
60.00	06000	LABORATORY	0	6,516	0		70,463	60.00
64.00	06400	INTRAVENOUS THERAPY	0	750	0		2,069	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,586	0		23,973	65.00
66.00	06600	PHYSICAL THERAPY	0	2,786	0		83,044	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	152	0		435	67.00
68.00	06800	SPEECH PATHOLOGY	0	15	0		71	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	245	0		39,708	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,091	3,074	0		31,357	73.00
76.00	03050	CARDIAC REHAB	0	92	0		24,800	76.00
76.01	03030	BEHAVIORAL HEALTH	0	495	0		9,996	76.01
76.02	03040	WOUND CARE	0	363	0		3,784	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0		132,740	90.00
91.00	09100	EMERGENCY	2,629	2,388	0		66,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,015	27,033	3,184	0	925,467	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		6,668	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		79,636	192.00
194.00	07950	MOB	0	0	0		0	194.00
194.01	07951	MOB	0	0	0		0	194.01
200.00		Cross Foot Adjustments				988	988	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	9,015	27,033	3,184	988	1,012,759	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING				5.03
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
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	253,837		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	94,478		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	2,059		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,064		54.00
60.00	06000	LABORATORY	0	70,463		60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,069		64.00
65.00	06500	RESPIRATORY THERAPY	0	23,973		65.00
66.00	06600	PHYSICAL THERAPY	0	83,044		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	435		67.00
68.00	06800	SPEECH PATHOLOGY	0	71		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,708		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,357		73.00
76.00	03050	CARDIAC REHAB	0	24,800		76.00
76.01	03030	BEHAVIORAL HEALTH	0	9,996		76.01
76.02	03040	WOUND CARE	0	3,784		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	132,740		90.00
91.00	09100	EMERGENCY	0	66,589		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	925,467		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,668		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	79,636		192.00
194.00	07950	MOB	0	0		194.00
194.01	07951	MOB	0	0		194.01
200.00		Cross Foot Adjustments	0	988		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	1,012,759		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-BLDG 1 (SQUARE FEET)	BLDG & FIXT-BLDG 2 (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	71,925					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1	0	2,427				1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2	0	0	69,498			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				71,573		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	89	0	89	89	5,736,218	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	4,834	754	4,080	4,834	563,108	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	155,760	5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	0	0	0	168,382	5.03
7.00	00700	OPERATION OF PLANT	23,797	707	23,090	23,797	186,546	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	915	136	779	915	4,006	8.00
9.00	00900	HOUSEKEEPING	606	45	561	606	175,280	9.00
10.00	01000	DIETARY	1,665	0	1,665	1,665	63,750	10.00
11.00	01100	CAFETERIA	1,342	0	1,342	1,342	51,386	11.00
13.00	01300	NURSING ADMINISTRATION	261	0	261	261	223,501	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,101	15	1,086	1,101	144,227	16.00
17.00	01700	SOCIAL SERVICE	104	0	104	104	60,713	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,699	0	7,699	7,699	862,002	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,994	0	3,994	3,994	173,478	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	82	0	82	82	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,069	0	3,069	3,069	427,234	54.00
60.00	06000	LABORATORY	2,498	178	2,320	2,498	470,755	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	92,576	64.00
65.00	06500	RESPIRATORY THERAPY	830	0	830	830	211,063	65.00
66.00	06600	PHYSICAL THERAPY	3,348	0	3,348	3,348	49,666	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,709	155	1,554	1,709	88,562	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	0	790	790	213,242	73.00
76.00	03050	CARDIAC REHAB	1,050	0	1,050	1,050	62,570	76.00
76.01	03030	BEHAVIORAL HEALTH	408	284	124	408	131,156	76.01
76.02	03040	WOUND CARE	153	153	0	153	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,500	0	5,500	5,500	643,094	90.00
91.00	09100	EMERGENCY	2,164	0	2,164	2,164	514,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,008	2,427	65,581	68,008	5,736,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	352	0	352	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,565	0	3,565	3,565	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	95,402	4,649	671,168	241,540	1,202,060	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.326409	1.915534	9.657371	3.374736	0.209556	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					1,278	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000223	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	DATA PROCESSING (ACCUM. COST)	BILLING, COLLECTION, & ADMITTING (GROSS CHARGES)	
			5A.01	5.01	5A.02	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-1,778,319	12,671,806				5.01
5.02	00550	DATA PROCESSING	0	210,868	-240,461	14,209,664		5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING	0	214,664	0	244,789	28,866,270	5.03
7.00	00700	OPERATION OF PLANT	0	1,042,812	0	1,189,157	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,780	0	70,450	0	8.00
9.00	00900	HOUSEKEEPING	0	253,139	0	288,664	0	9.00
10.00	01000	DIETARY	0	151,072	0	172,273	0	10.00
11.00	01100	CAFETERIA	0	90,609	0	103,325	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	288,189	0	328,633	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	227,208	0	259,094	0	16.00
17.00	01700	SOCIAL SERVICE	0	75,436	0	86,022	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	193,100	0	220,199	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,307,774	0	1,491,303	798,065	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	302,073	0	344,465	329,956	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	5,724	0	6,527	176,555	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,129,567	0	1,288,087	7,839,132	54.00
60.00	06000	LABORATORY	0	986,658	0	1,125,123	6,961,436	60.00
64.00	06400	INTRAVENOUS THERAPY	0	119,659	0	136,452	801,014	64.00
65.00	06500	RESPIRATORY THERAPY	0	387,967	0	442,413	1,694,051	65.00
66.00	06600	PHYSICAL THERAPY	0	773,125	0	881,623	2,976,103	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	54,045	0	61,630	162,140	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,677	0	12,175	15,958	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	254,487	0	290,201	262,130	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,489,157	0	1,698,141	3,283,671	73.00
76.00	03050	CARDIAC REHAB	0	91,298	0	104,110	98,370	76.00
76.01	03030	BEHAVIORAL HEALTH	0	289,840	0	330,515	528,745	76.01
76.02	03040	WOUND CARE	0	220,012	0	250,888	387,424	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	681,837	0	777,524	0	90.00
91.00	09100	EMERGENCY	0	1,703,974	0	1,943,099	2,551,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,778,319	12,616,751	-240,461	14,146,882	28,866,270	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,866	0	4,409	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51,189	0	58,373	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)		1,778,319		240,461	248,931	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.140337		0.016922	0.008624	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		63,697		1,095	1,136	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005027		0.000077	0.000039	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
7.00	00700	OPERATION OF PLANT	43,205					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	915	1,000				8.00
9.00	00900	HOUSEKEEPING	606	0	37,767			9.00
10.00	01000	DIETARY	1,665	0	1,665	1,000		10.00
11.00	01100	CAFETERIA	1,342	0	1,342	0	4,368,000	11.00
13.00	01300	NURSING ADMINISTRATION	261	0	261	0	223,501	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,101	0	1,101	0	144,227	16.00
17.00	01700	SOCIAL SERVICE	104	0	104	0	60,713	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,699	1,000	7,699	1,000	862,002	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,994	0	3,994	0	173,478	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	82	0	82	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,069	0	3,069	0	427,234	54.00
60.00	06000	LABORATORY	2,498	0	2,498	0	470,755	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	92,576	64.00
65.00	06500	RESPIRATORY THERAPY	830	0	830	0	211,063	65.00
66.00	06600	PHYSICAL THERAPY	3,348	0	3,348	0	49,666	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,709	0	1,709	0	88,562	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	0	790	0	213,242	73.00
76.00	03050	CARDIAC REHAB	1,050	0	1,050	0	62,570	76.00
76.01	03030	BEHAVIORAL HEALTH	408	0	408	0	131,156	76.01
76.02	03040	WOUND CARE	153	0	153	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,500	0	5,500	0	643,094	90.00
91.00	09100	EMERGENCY	2,164	0	2,164	0	514,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,288	1,000	37,767	1,000	4,368,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	352	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,565	0	0	0	0	192.00
194.00	07950	MOB	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
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)	1,209,280	97,252	310,511	235,479	153,669	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.989353	97.252000	8.221754	235.479000	0.035181	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	341,589	19,637	14,478	38,495	30,867	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.906238	19.637000	0.383351	38.495000	0.007067	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 8:34 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT- BLDG 1						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT- BLDG 2						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	BILLING, COLLECTION, & ADMITTING						5.03
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	1,762,883					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,866,270				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,000			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	862,002	798,065	1,000	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	173,478	329,956	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	176,555	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,839,132	0	0		54.00
60.00	06000	LABORATORY	0	6,961,436	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	801,014	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,694,051	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,976,103	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	162,140	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	15,958	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	262,130	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,242	3,283,671	0	0		73.00
76.00	03050	CARDIAC REHAB	0	98,370	0	0		76.00
76.01	03030	BEHAVIORAL HEALTH	0	528,745	0	0		76.01
76.02	03040	WOUND CARE	0	387,424	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	514,161	2,551,520	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,762,883	28,866,270	1,000	100		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	0	0	0	0		192.00
194.00	07950	MOB	0	0	0	0		194.00
194.01	07951	MOB	0	0	0	0		194.01
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)	351,508	308,420	93,380	223,925		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.199394	0.010684	93.380000	2,239.250000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,015	27,033	3,184	988		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.005114	0.000936	3.184000	9.880000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,439,053		2,439,053	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	541,985		541,985	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	236,940		236,940	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,587,407		1,587,407	0	0	54.00
60.00	06000	LABORATORY	1,385,590		1,385,590	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	157,484		157,484	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	520,088	0	520,088	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,076,986	0	1,076,986	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	65,803	0	65,803	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,689	0	12,689	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	365,175		365,175	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,868,906		1,868,906	0	0	73.00
76.00	03050	CARDIAC REHAB	147,994		147,994	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	365,705		365,705	0	0	76.01
76.02	03040	WOUND CARE	268,154		268,154	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,012,467		1,012,467	0	0	90.00
91.00	09100	EMERGENCY	2,224,220		2,224,220	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	202,995		202,995		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,479,641	0	14,479,641	0	0	200.00
201.00		Less Observation Beds	202,995		202,995		0	201.00
202.00		Total (see instructions)	14,276,646	0	14,276,646	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | 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	713,630		713,630			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	329,956	329,956	1.642598	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	176,555	176,555	1.342018	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	145,899	7,693,233	7,839,132	0.202498	0.000000	54.00
60.00	06000	LABORATORY	415,143	6,546,293	6,961,436	0.199038	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	44,743	756,271	801,014	0.196606	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	188,324	1,505,727	1,694,051	0.307008	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	216,860	2,759,243	2,976,103	0.361878	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,985	72,155	162,140	0.405841	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,990	13,968	15,958	0.795150	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	88,330	173,800	262,130	1.393106	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	235,238	3,048,433	3,283,671	0.569151	0.000000	73.00
76.00	03050	CARDIAC REHAB	3,852	94,518	98,370	1.504463	0.000000	76.00
76.01	03030	BEHAVIORAL HEALTH	0	528,745	528,745	0.691647	0.000000	76.01
76.02	03040	WOUND CARE	0	387,424	387,424	0.692146	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	530,778	530,778	1.907515	0.000000	90.00
91.00	09100	EMERGENCY	15,730	2,535,790	2,551,520	0.871724	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	84,435	84,435	2.404157	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,159,724	27,237,324	29,397,048			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,159,724	27,237,324	29,397,048			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		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
60.00	06000	LABORATORY	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03050	CARDIAC REHAB	0.000000	76.00
76.01	03030	BEHAVIORAL HEALTH	0.000000	76.01
76.02	03040	WOUND CARE	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | 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	94,478	329,956	0.286335	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	2,059	176,555	0.011662	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,064	7,839,132	0.010979	70,280	772	54.00
60.00	06000	LABORATORY	70,463	6,961,436	0.010122	223,206	2,259	60.00
64.00	06400	INTRAVENOUS THERAPY	2,069	801,014	0.002583	24,370	63	64.00
65.00	06500	RESPIRATORY THERAPY	23,973	1,694,051	0.014151	106,167	1,502	65.00
66.00	06600	PHYSICAL THERAPY	83,044	2,976,103	0.027904	52,170	1,456	66.00
67.00	06700	OCCUPATIONAL THERAPY	435	162,140	0.002683	18,845	51	67.00
68.00	06800	SPEECH PATHOLOGY	71	15,958	0.004449	240	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,708	262,130	0.151482	41,473	6,282	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,357	3,283,671	0.009549	91,349	872	73.00
76.00	03050	CARDIAC REHAB	24,800	98,370	0.252109	800	202	76.00
76.01	03030	BEHAVIORAL HEALTH	9,996	528,745	0.018905	0	0	76.01
76.02	03040	WOUND CARE	3,784	387,424	0.009767	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	132,740	530,778	0.250086	0	0	90.00
91.00	09100	EMERGENCY	66,589	2,551,520	0.026098	7,905	206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	21,126	84,435	0.250204	0	0	92.00
200.00		Total (lines 50-199)	692,756	28,683,418		636,805	13,666	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | 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	223,925	0	0	0	223,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03050	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0	0	0	76.01
76.02	03040	WOUND CARE	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	223,925	0	0	0	223,925	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | 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	329,956	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	176,555	1.268302	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,839,132	0.000000	0.000000	70,280	54.00
60.00	06000	LABORATORY	0	6,961,436	0.000000	0.000000	223,206	60.00
64.00	06400	INTRAVENOUS THERAPY	0	801,014	0.000000	0.000000	24,370	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,694,051	0.000000	0.000000	106,167	65.00
66.00	06600	PHYSICAL THERAPY	0	2,976,103	0.000000	0.000000	52,170	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	162,140	0.000000	0.000000	18,845	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,958	0.000000	0.000000	240	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	262,130	0.000000	0.000000	41,473	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,283,671	0.000000	0.000000	91,349	73.00
76.00	03050	CARDIAC REHAB	0	98,370	0.000000	0.000000	800	76.00
76.01	03030	BEHAVIORAL HEALTH	0	528,745	0.000000	0.000000	0	76.01
76.02	03040	WOUND CARE	0	387,424	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	530,778	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,551,520	0.000000	0.000000	7,905	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	84,435	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	28,683,418			636,805	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | 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
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03050	CARDIAC REHAB	0	0	0		76.00
76.01	03030	BEHAVIORAL HEALTH	0	0	0		76.01
76.02	03040	WOUND CARE	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

		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	1.642598	0	168,211	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.342018	0	89,850	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202498	0	2,995,419	0	0	54.00
60.00	06000	LABORATORY	0.199038	0	2,909,399	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.196606	0	342,205	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.307008	0	668,305	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.361878	0	914,050	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405841	0	11,425	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.795150	0	3,299	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.393106	0	93,156	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.569151	0	1,736,086	0	0	73.00
76.00	03050	CARDIAC REHAB	1.504463	0	76,730	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.691647	0	446,725	0	0	76.01
76.02	03040	WOUND CARE	0.692146	0	237,106	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.907515	0	206,053	0	0	90.00
91.00	09100	EMERGENCY	0.871724	0	798,038	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.404157	0	40,830	0	0	92.00
200.00		Subtotal (see instructions)		0	11,736,887	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	11,736,887	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

		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	276,303	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	120,580	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	606,566	0		54.00
60.00	06000	LABORATORY	579,081	0		60.00
64.00	06400	INTRAVENOUS THERAPY	67,280	0		64.00
65.00	06500	RESPIRATORY THERAPY	205,175	0		65.00
66.00	06600	PHYSICAL THERAPY	330,775	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,637	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,623	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,776	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	988,095	0		73.00
76.00	03050	CARDIAC REHAB	115,437	0		76.00
76.01	03030	BEHAVIORAL HEALTH	308,976	0		76.01
76.02	03040	WOUND CARE	164,112	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	393,049	0		90.00
91.00	09100	EMERGENCY	695,669	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	98,162	0		92.00
200.00		Subtotal (see instructions)	5,086,296	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,086,296	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Swing Beds - SNF | Cost

		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	1.642598	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.342018	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202498	0	0	0	0	54.00
60.00	06000	LABORATORY	0.199038	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.196606	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.307008	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.361878	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405841	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.795150	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.393106	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.569151	0	0	0	0	73.00
76.00	03050	CARDIAC REHAB	1.504463	0	0	0	0	76.00
76.01	03030	BEHAVIORAL HEALTH	0.691647	0	0	0	0	76.01
76.02	03040	WOUND CARE	0.692146	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.907515	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.871724	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.404157	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Swing Beds - SNF | Cost

		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
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03050	CARDIAC REHAB	0	0		76.00
76.01	03030	BEHAVIORAL HEALTH	0	0		76.01
76.02	03040	WOUND CARE	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

	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)	1,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	678	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)	593	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	168	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)	167	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	68	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)	67	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	386	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)	168	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)	167	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	143.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	150.15	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,439,053	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)	9,765	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)	10,060	25.00
26.00	Total swing-bed cost (see instructions)	819,865	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,619,188	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)	1,619,188	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)	2,388.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	921,837	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)	921,837	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	240,623	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,162,460	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	401,214	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	398,826	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	800,040	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)	85	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,388.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	202,995	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

	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	253,837	2,439,053	0.104072	202,995	21,126	90.00
91.00	Nursing School cost	0	2,439,053	0.000000	202,995	0	91.00
92.00	Allied health cost	0	2,439,053	0.000000	202,995	0	92.00
93.00	All other Medical Education	0	2,439,053	0.000000	202,995	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		309,145		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.642598	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.342018	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202498	70,280	14,232	54.00
60.00	06000	LABORATORY	0.199038	223,206	44,426	60.00
64.00	06400	INTRAVENOUS THERAPY	0.196606	24,370	4,791	64.00
65.00	06500	RESPIRATORY THERAPY	0.307008	106,167	32,594	65.00
66.00	06600	PHYSICAL THERAPY	0.361878	52,170	18,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405841	18,845	7,648	67.00
68.00	06800	SPEECH PATHOLOGY	0.795150	240	191	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.393106	41,473	57,776	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.569151	91,349	51,991	73.00
76.00	03050	CARDIAC REHAB	1.504463	800	1,204	76.00
76.01	03030	BEHAVIORAL HEALTH	0.691647	0	0	76.01
76.02	03040	WOUND CARE	0.692146	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.907515	0	0	90.00
91.00	09100	EMERGENCY	0.871724	7,905	6,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.404157	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		636,805	240,623	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)		636,805		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.642598	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1.342018	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202498	14,215	2,879	54.00
60.00	06000	LABORATORY	0.199038	53,628	10,674	60.00
64.00	06400	INTRAVENOUS THERAPY	0.196606	5,423	1,066	64.00
65.00	06500	RESPIRATORY THERAPY	0.307008	36,001	11,053	65.00
66.00	06600	PHYSICAL THERAPY	0.361878	107,750	38,992	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.405841	47,905	19,442	67.00
68.00	06800	SPEECH PATHOLOGY	0.795150	1,225	974	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.393106	24,360	33,936	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.569151	67,874	38,631	73.00
76.00	03050	CARDIAC REHAB	1.504463	1,392	2,094	76.00
76.01	03030	BEHAVIORAL HEALTH	0.691647	0	0	76.01
76.02	03040	WOUND CARE	0.692146	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.907515	0	0	90.00
91.00	09100	EMERGENCY	0.871724	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.404157	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		359,773	159,741	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)		359,773		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part B Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,086,296	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,086,296	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,137,159	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	65,471	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,759,310	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)	3,312,378	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)	3,312,378	30.00
31.00	Primary payer payments	1,580	31.00
32.00	Subtotal (line 30 minus line 31)	3,310,798	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)	171,909	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	111,741	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	160,807	36.00
37.00	Subtotal (see instructions)	3,422,539	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,422,539	40.00
40.01	Sequestration adjustment (see instructions)	68,451	40.01
41.00	Interim payments	3,354,418	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-330	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: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		951,376		3,181,764	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	06/23/2016	79,669	02/12/2016	7,624	3.01
3.02			0	06/23/2016	165,030	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	02/12/2016	17,208		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)		62,461		172,654	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,013,837		3,354,418	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		7,970		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		330	6.02
7.00	Total Medicare program liability (see instructions)		1,021,807		3,354,088	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: 141306 | Component CCN: 14Z306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		868,886		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	06/23/2016	8,755		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	02/12/2016	12,679		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)		-3,924		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)		864,962		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		84,713		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		949,675		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141306	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/21/2016 8:34 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	237	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	386	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	63	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	593	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	29,397,048	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	31,048	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	219,234	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	210,026	8.00
9.00	Sequestration adjustment amount (see instructions)	4,201	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	205,825	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	214,849	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-9,024	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141306 | Component CCN: 14Z306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-2 | Date/Time Prepared: 11/21/2016 8:34 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	808,040	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)	161,338	0	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	335	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)	969,378	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	969,378	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)	969,378	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	322	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)	969,056	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)	969,056	0	19.00
19.01	Sequestration adjustment (see instructions)	19,381	0	19.01
20.00	Interim payments	864,962	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)	84,713	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141306	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/21/2016 8:34 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,162,460	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,162,460	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,174,085	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,174,085	19.00
20.00	Deductibles (exclude professional component)	134,149	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,039,936	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,039,936	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,191	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	2,724	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	4,191	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,042,660	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,042,660	30.00
30.01	Sequestration adjustment (see instructions)	20,853	30.01
31.00	Interim payments	1,013,837	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	7,970	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/21/2016 8:34 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	1,827,703	0	0	0	1.00
2.00	Temporary investments	3,278,883	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,655,689	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	309,496	0	0	0	7.00
8.00	Prepaid expenses	175,776	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,247,547	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	546,486	0	0	0	12.00
13.00	Land improvements	2,307,839	0	0	0	13.00
14.00	Accumulated depreciation	-332,371	0	0	0	14.00
15.00	Buildings	8,492,252	0	0	0	15.00
16.00	Accumulated depreciation	-2,400,462	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,837,413	0	0	0	19.00
20.00	Accumulated depreciation	-1,379,579	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	5,025,693	0	0	0	23.00
24.00	Accumulated depreciation	-3,834,202	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,263,069	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	491,735	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	834,939	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,326,674	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,837,290	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	825,560	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,175,283	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	411,763	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	159,997	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,572,603	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	10,752,730	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	284,654	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,037,384	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,609,987	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	13,227,303				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	13,227,303	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,837,290	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/21/2016 8:34 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		13,069,227		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		904,795				2.00
3.00	Total (sum of line 1 and line 2)		13,974,022		0		3.00
4.00	CHANGE IN INTEREST IN NET ASSETS	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		13,974,022		0		11.00
12.00	CHANGE IN INTEREST IN NET ASSETS	746,719		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		746,719		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,227,303		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	CHANGE IN INTEREST IN NET ASSETS		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	CHANGE IN INTEREST IN NET ASSETS		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/21/2016 8:34 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	525,794		525,794	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	167,800		167,800	5.00
6.00	Swing bed - NF	20,036		20,036	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)	713,630		713,630	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	713,630		713,630	17.00
18.00	Ancillary services	1,430,364	23,443,786	24,874,150	18.00
19.00	Outpatient services	15,730	4,290,384	4,306,114	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		0	0	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	121,982	1,572,076	1,694,058	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,281,706	29,306,246	31,587,952	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,054,241		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)		16,054,241		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141306 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-3 | Date/Time Prepared: 11/21/2016 8:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	31,587,952	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,249,252	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,338,700	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,054,241	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-715,541	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,086,290	6.00
7.00	Income from investments	38,337	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	19,183	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	31,923	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	2,081	16.00
17.00	Revenue from sale of drugs to other than patients	4,765	17.00
18.00	Revenue from sale of medical records and abstracts	6,536	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	33,724	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	398,467	24.00
24.01	LOSS ON DISPOSAL OF ASSETS	-970	24.01
25.00	Total other income (sum of lines 6-24)	1,620,336	25.00
26.00	Total (line 5 plus line 25)	904,795	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	904,795	29.00