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: 141350	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/28/2016 4:12 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2016 Time: 4:12 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 ST. FRANCIS HOSPITAL (141350) 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	589,285	405,784	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	114,723	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	704,008	405,784	0	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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 4:11 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1215 FRANCISCAN DRIVE	PO Box:			1.00
2.00	City: LITCHFIELD	State: IL	Zip Code: 62056	County: MONTGOMERY	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	ST. FRANCIS HOSPITAL	141350	99914	1	12/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. FRANCIS HOSPITAL	14Z350	99914		05/31/2007	N	O	O	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	1	N	23.00

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

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		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)				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.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	455,604	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 4:11 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	148005	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: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONA GOVERNMENT SERVICES	Contractor's Number: 00131	141.00
142.00	Street: 4736 LAVERNA ROAD	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62794	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	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)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	N	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: 141350	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 4:11 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	06/30/2016	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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/28/2016 4:11 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	10/19/2016	Y	10/19/2016
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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 4:11 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.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		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.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	211 N BROADWAY STE 600, ST LOUIS, MO	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141350	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 4:11 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 11/28/2016 4:11 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	109,832.00	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	109,832.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	109,832.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2016 4:11 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,859	548	4,243			1.00
2.00	HMO and other (see instructions)	209	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	785	0	785			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	145			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,644	548	5,173			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		303	402			13.00
14.00	Total (see instructions)	3,644	851	5,575	0.00	211.07	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	211.07	27.00
28.00	Observation Bed Days		118	534			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			32			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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/28/2016 4:11 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	760	270	1,375	1.00
2.00	HMO and other (see instructions)			67	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	760	270	1,375	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/28/2016 4:11 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)	0.291399	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,146,354	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	26,839,284	6.00
7.00	Medicaid cost (line 1 times line 6)	7,820,941	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)	674,587	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	142,364	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	197,026	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)	674,587	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	1,473,067	440,176	1,913,243	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	429,250	128,267	557,517	21.00
22.00	Partial payment by patients approved for charity care	31	10,615	10,646	22.00
23.00	Cost of charity care (line 21 minus line 22)	429,219	117,652	546,871	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,910,770	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	606,250	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,304,520	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	380,136	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	927,007	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,601,594	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/28/2016 4:11 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		1,555,478	1,555,478	14,313	1,569,791	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,257,218	1,257,218	-720	1,256,498	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	78,822	8,973,885	9,052,707	0	9,052,707	4.00
5.01	00570	ADMITTING	476,605	83,741	560,346	-173,496	386,850	5.01
5.02	00540	PATIENT ACCOUNTING	8,396	600,712	609,108	8	609,116	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	1,198,021	7,108,289	8,306,310	-413,818	7,892,492	5.03
6.00	00600	MAINTENANCE & REPAIRS	263,374	29,865	293,239	0	293,239	6.00
7.00	00700	OPERATION OF PLANT	64,457	1,053,914	1,118,371	0	1,118,371	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	129,929	129,929	8.00
9.00	00900	HOUSEKEEPING	274,423	211,347	485,770	0	485,770	9.00
10.00	01000	DIETARY	333,777	187,478	521,255	-428,119	93,136	10.00
11.00	01100	CAFETERIA	0	0	0	428,067	428,067	11.00
13.00	01300	NURSING ADMINISTRATION	253,288	36,910	290,198	3,025	293,223	13.00
15.00	01500	PHARMACY	406,746	870,315	1,277,061	-717,981	559,080	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,066	0	4,066	509,275	513,341	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,496,108	275,180	2,771,288	-869,519	1,901,769	30.00
43.00	04300	NURSERY	0	0	0	88,125	88,125	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,099,417	1,497,815	2,597,232	-1,038,687	1,558,545	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	564,395	564,395	52.00
53.00	05300	ANESTHESIOLOGY	0	683,681	683,681	-31,455	652,226	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	842,646	470,949	1,313,595	-28,103	1,285,492	54.00
57.00	05700	CT SCAN	113,246	195,093	308,339	13,322	321,661	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	84,372	130,632	215,004	6,092	221,096	58.00
60.00	06000	LABORATORY	554,588	1,163,878	1,718,466	106,580	1,825,046	60.00
65.00	06500	RESPIRATORY THERAPY	343,699	209,222	552,921	23,712	576,633	65.00
66.00	06600	PHYSICAL THERAPY	224,474	530,200	754,674	-1,075	753,599	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	94,753	94,753	324,578	419,331	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	813,901	813,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	717,981	717,981	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	138,692	18,524	157,216	0	157,216	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	139,125	901,658	1,040,783	-958	1,039,825	90.00
91.00	09100	EMERGENCY	1,116,680	1,203,416	2,320,096	-68,277	2,251,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,515,022	29,344,153	39,859,175	-28,905	39,830,270	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,057	39,057	0	39,057	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	138,361	304,012	442,373	28,396	470,769	192.00
194.00	07950	OTHER NONALLOWABLE	143,101	198,995	342,096	509	342,605	194.00
200.00		TOTAL (SUM OF LINES 118-199)	10,796,484	29,886,217	40,682,701	0	40,682,701	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/28/2016 4:11 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	1,569,791		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-834,621	421,877		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,611,238	4,441,469		4.00
5.01	00570	ADMITTING	0	386,850		5.01
5.02	00540	PATIENT ACCOUNTING	0	609,116		5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-1,038,012	6,854,480		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	293,239		6.00
7.00	00700	OPERATION OF PLANT	0	1,118,371		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,929		8.00
9.00	00900	HOUSEKEEPING	0	485,770		9.00
10.00	01000	DIETARY	0	93,136		10.00
11.00	01100	CAFETERIA	0	428,067		11.00
13.00	01300	NURSING ADMINISTRATION	0	293,223		13.00
15.00	01500	PHARMACY	0	559,080		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	513,341		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,901,769		30.00
43.00	04300	NURSERY	0	88,125		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,558,545		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	564,395		52.00
53.00	05300	ANESTHESIOLOGY	-562,363	89,863		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-105,231	1,180,261		54.00
57.00	05700	CT SCAN	0	321,661		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	221,096		58.00
60.00	06000	LABORATORY	0	1,825,046		60.00
65.00	06500	RESPIRATORY THERAPY	0	576,633		65.00
66.00	06600	PHYSICAL THERAPY	0	753,599		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	419,331		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	813,901		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	717,981		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	157,216		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-793,398	246,427		90.00
91.00	09100	EMERGENCY	0	2,251,819		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,944,863	31,885,407		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,057		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	470,769		192.00
194.00	07950	OTHER NONALLOWABLE	0	342,605		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-7,944,863	32,737,838		200.00

RECLASSIFICATIONS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/28/2016 4:11 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - L&D AND NURSERY SAL & OTHER EXP				
1.00	NURSERY	43.00	84,060	10,489	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	538,360	67,178	2.00
	TOTALS		622,420	77,667	
	B - DRUG COSTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	717,981	1.00
	TOTALS		0	717,981	
	C - CAFETERIA SALARIES & OTHER COSTS				
1.00	CAFETERIA	11.00	287,115	140,952	1.00
	TOTALS		287,115	140,952	
	D - LAUNDRY COSTS				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	129,929	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	129,929	
	E - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	387,131	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	751,348	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	1,138,479	
	F - LAB ADMINISTRATION COSTS				
1.00	LABORATORY	60.00	96,776	12,262	1.00
2.00		0.00	0	0	2.00
	TOTALS		96,776	12,262	
	G - MOB DEPRECIATION COSTS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	30,066	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	30,066	
	H - SHARED SERVICES COSTS				
1.00	ADMITTING	5.01	13,542	0	1.00
2.00	PATIENT ACCOUNTING	5.02	8	0	2.00
3.00	NURSING ADMINISTRATION	13.00	3,025	0	3.00
4.00	CT SCAN	57.00	5,075	0	4.00
5.00	LABORATORY	60.00	240	0	5.00
6.00	RESPIRATORY THERAPY	65.00	25,288	0	6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	235	0	7.00
8.00	OTHER NONALLOWABLE	194.00	509	0	8.00
	TOTALS		47,922	0	
	I - BUILDING INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	43,659	1.00
	TOTALS		0	43,659	
	J - RADIOLOGY MANAGERS COST				
1.00	CT SCAN	57.00	11,331	0	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	7,635	0	2.00
	TOTALS		18,966	0	
	K - MEDICAL RECORDS COSTS FROM A&G				
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	509,275	1.00
	TOTALS		0	509,275	
	M - CASE MANAGEMENT TO A&G				
1.00	ADMINISTRATIVE & GENERAL	5.03	136,347	50,691	1.00
	TOTALS		136,347	50,691	
	O - SEGREGATE DIRECT COSTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	62,553	1.00
	TOTALS		0	62,553	
500.00	Grand Total: Increases		1,209,546	2,913,514	500.00

RECLASSIFICATIONS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/28/2016 4:11 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - L&D AND NURSERY SAL & OTHER EXP					
1.00	ADULTS & PEDIATRICS	30.00	622,420	77,667	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		622,420	77,667		
	B - DRUG COSTS					
1.00	PHARMACY	15.00	0	717,981	0	1.00
	TOTALS		0	717,981		
	C - CAFETERIA SALARIES & OTHER COSTS					
1.00	DIETARY	10.00	287,115	140,952	0	1.00
	TOTALS		287,115	140,952		
	D - LAUNDRY COSTS					
1.00	DIETARY	10.00	0	52	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	57,437	0	2.00
3.00	NURSERY	43.00	0	1,605	0	3.00
4.00	OPERATING ROOM	50.00	0	18,311	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	10,278	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,137	0	6.00
7.00	CT SCAN	57.00	0	3,084	0	7.00
8.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,543	0	8.00
9.00	LABORATORY	60.00	0	2,698	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	1,576	0	10.00
11.00	PHYSICAL THERAPY	66.00	0	1,075	0	11.00
12.00	CLINIC	90.00	0	958	0	12.00
13.00	EMERGENCY	91.00	0	20,270	0	13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,905	0	14.00
	TOTALS		0	129,929		
	E - MEDICAL SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	5,361	0	1.00
2.00	NURSERY	43.00	0	4,819	0	2.00
3.00	OPERATING ROOM	50.00	0	1,020,376	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	0	30,865	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	31,455	0	5.00
6.00	EMERGENCY	91.00	0	45,603	0	6.00
	TOTALS		0	1,138,479		
	F - LAB ADMINISTRATION COSTS					
1.00	ADULTS & PEDIATRICS	30.00	95,585	11,049	0	1.00
2.00	EMERGENCY	91.00	1,191	1,213	0	2.00
	TOTALS		96,776	12,262		
	G - MOB DEPRECIATION COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	29,346	9	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	720	9	2.00
	TOTALS		0	30,066		
	H - SHARED SERVICES COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.03	47,922	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
	TOTALS		47,922	0		
	I - BUILDING INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.03	0	43,659	12	1.00
	TOTALS		0	43,659		
	J - RADIOLOGY MANAGERS COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	18,966	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		18,966	0		
	K - MEDICAL RECORDS COSTS FROM A&G					
1.00	ADMINISTRATIVE & GENERAL	5.03	0	509,275	0	1.00
	TOTALS		0	509,275		
	M - CASE MANAGEMENT TO A&G					
1.00	ADMITTING	5.01	136,347	50,691	0	1.00
	TOTALS		136,347	50,691		
	O - SEGREGATE DIRECT COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	62,553	0	1.00
	TOTALS		0	62,553		
500.00	Grand Total: Decreases		1,209,546	2,913,514		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/28/2016 4:11 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	99,383	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,824,801	16,280	0	16,280	4,965	3.00
4.00	Building Improvements	34,855,466	613,794	0	613,794	415,384	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	20,197,647	810,684	0	810,684	289,797	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,977,297	1,440,758	0	1,440,758	710,146	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	56,977,297	1,440,758	0	1,440,758	710,146	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	99,383	0	2.00
3.00	Buildings and Fixtures	1,836,116	0	3.00
4.00	Building Improvements	35,053,876	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	20,718,534	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	57,707,909	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	57,707,909	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/28/2016 4:11 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	1,555,478	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,257,218	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,812,696	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	1,555,478	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,257,218	2.00
3.00	Total (sum of lines 1-2)	0	2,812,696	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/28/2016 4:11 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	36,989,375	0	36,989,375	0.640976	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,718,534	0	20,718,534	0.359024	0	2.00
3.00	Total (sum of lines 1-2)	57,707,909	0	57,707,909	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,526,132	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	421,877	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,948,009	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	43,659	0	0	1,569,791	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	421,877	2.00
3.00	Total (sum of lines 1-2)	0	43,659	0	0	1,991,668	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/28/2016 4:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,460,992			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	979,291			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-834,621	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC	B	-30,339	ADMINISTRATIVE & GENERAL	5.03	0	33.00
33.01	ADMIN REVENUE	B	-493	ADMINISTRATIVE & GENERAL	5.03	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/28/2016 4:11 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	TAX PENALTY	A	-23,514	ADMINISTRATIVE & GENERAL	5.03	0	33.02
33.03	FUND DEVELOPMENT	A	-24,664	ADMINISTRATIVE & GENERAL	5.03	0	33.03
33.04	PHYSICIAN RECRUITMENT	A	-6,963	ADMINISTRATIVE & GENERAL	5.03	0	33.04
33.05	MEDICAID TAX ASSESSMENT	A	-1,128,906	ADMINISTRATIVE & GENERAL	5.03	0	33.05
33.06	SELF-INS TO HOSP/EMP CLIMS	A	-665,139	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	LOBBYING EXPENSES	A	-16,412	ADMINISTRATIVE & GENERAL	5.03	0	33.07
33.08	ALCOHOL BEVERAGE COST	A	-878	ADMINISTRATIVE & GENERAL	5.03	0	33.08
33.09	DEFINED PENSION ADJUSTMENT	A	-3,952,582	EMPLOYEE BENEFITS DEPARTMENT	4.00	9	33.09
33.10	OFFSET CONTRIBUTION EXPENSE	A	-777,695	ADMINISTRATIVE & GENERAL	5.03	0	33.10
33.11	BANK CHARGES	A	-956	ADMINISTRATIVE & GENERAL	5.03	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,944,863				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/28/2016 4:11 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF-INS PREMIUMS	2,889,789	2,883,306	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SVCS	4,798	4,798	2.00
3.00	5.03	ADMINISTRATIVE & GENERAL	CONTRACT SERVICES - HSHS	3,426,621	2,453,813	3.00
3.01	5.03	ADMINISTRATIVE & GENERAL	RELATED PARTY SVCS	560,853	560,853	3.01
3.02	5.01	ADMITTING	RELATED PARTY SVCS	20,244	20,244	3.02
3.03	5.02	PATIENT ACCOUNTING	RELATED PARTY SVCS	90,669	90,669	3.03
3.04	9.00	HOUSEKEEPING	RELATED PARTY SVCS	192	192	3.04
3.05	10.00	DIETARY	RELATED PARTY SVCS	745	745	3.05
3.06	13.00	NURSING ADMINISTRATION	RELATED PARTY SVCS	4,448	4,448	3.06
3.07	15.00	PHARMACY	RELATED PARTY SVCS	9,368	9,368	3.07
3.08	30.00	ADULTS & PEDIATRICS	RELATED PARTY SVCS	11,545	11,545	3.08
3.09	50.00	OPERATING ROOM	RELATED PARTY SVCS	2,472	2,472	3.09
3.10	54.00	RADIOLOGY-DIAGNOSTIC	RELATED PARTY SVCS	6,532	6,532	3.10
3.11	57.00	CT SCAN	RELATED PARTY SVCS	5,158	5,158	3.11
3.12	58.00	MAGNETIC RESONANCE IMAGING (	RELATED PARTY SVCS	46	46	3.12
3.13	60.00	LABORATORY	RELATED PARTY SVCS	162,614	162,614	3.13
3.14	65.00	RESPIRATORY THERAPY	RELATED PARTY SVCS	113,100	113,100	3.14
3.15	66.00	PHYSICAL THERAPY	RELATED PARTY SVCS	178	178	3.15
3.16	90.00	CLINIC	RELATED PARTY SVCS	85,169	85,169	3.16
3.17	91.00	EMERGENCY	RELATED PARTY SVCS	1,220	1,220	3.17
3.18	190.00	GIFT, FLOWER, COFFEE SHOP &	RELATED PARTY SVCS	8,000	8,000	3.18
3.19	192.00	PHYSICIANS' PRIVATE OFFICES	RELATED PARTY SVCS	5,349	5,349	3.19
3.20	194.00	OTHER NONALLOWABLE	RELATED PARTY SVCS	16,513	16,513	3.20
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,425,623	6,446,332	5.00

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

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

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

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

6.00	B	HSHS	100.00	HSHS	0.00	6.00
7.00	G	HSHS	100.00	ST MARY'S HOSP	0.00	7.00
8.00	G	HSHS	100.00	ST. JOHN'S HOSP	0.00	8.00
9.00	G	HSHS	100.00	ST. JOE- BREESE	0.00	9.00
10.00	G	HSHS	100.00	ST. ELIZABETH H	0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141350	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/28/2016 4:11 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	6,483	0		1.00
2.00	0	0		2.00
3.00	972,808	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
3.19	0	0		3.19
3.20	0	0		3.20
4.00	0	0		4.00
5.00	979,291			5.00

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

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

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

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

6.00	CORPORATE		6.00
7.00	HOSPITAL		7.00
8.00	HOSPITAL		8.00
9.00	HOSPITAL		9.00
10.00	HOSPITAL		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/28/2016 4:11 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	53.00	ANESTHESIOLOGY	562,363	562,363	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	105,231	105,231	0	0	0	2.00
3.00	91.00	EMERGENCY	1,103,317	0	1,103,317	0	0	3.00
4.00	90.00	CLINIC	793,398	793,398	0	0	0	4.00
5.00	5.03	ADMINISTRATIVE & GENERAL	54,477	0	54,477	0	0	5.00
6.00	0.00		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			2,618,786	1,460,992	1,157,794		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0	0	5.00
6.00	0.00		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	53.00	ANESTHESIOLOGY	0	0	0	562,363		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	105,231		2.00
3.00	91.00	EMERGENCY	0	0	0	0		3.00
4.00	90.00	CLINIC	0	0	0	793,398		4.00
5.00	5.03	ADMINISTRATIVE & GENERAL	0	0	0	0		5.00
6.00	0.00		0	0	0	0		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	1,460,992		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,569,791	1,569,791				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	421,877		421,877			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,441,469	5,671	0	4,447,140		4.00
5.01	00570	ADMITTING	386,850	26,452	0	146,804	560,106	5.01
5.02	00540	PATIENT ACCOUNTING	609,116	2,053	0	3,487	0	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	6,854,480	137,051	57,107	533,793	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	293,239	0	0	109,283	0	6.00
7.00	00700	OPERATION OF PLANT	1,118,371	374,807	0	26,746	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	129,929	13,546	0	0	0	8.00
9.00	00900	HOUSEKEEPING	485,770	29,590	409	113,868	0	9.00
10.00	01000	DIETARY	93,136	80,245	4,254	24,760	0	10.00
11.00	01100	CAFETERIA	428,067	26,239	0	113,736	0	11.00
13.00	01300	NURSING ADMINISTRATION	293,223	9,777	7,306	106,353	0	13.00
15.00	01500	PHARMACY	559,080	16,728	6,336	168,774	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	513,341	17,190	0	1,687	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,901,769	178,694	26,202	737,796	25,299	30.00
43.00	04300	NURSERY	88,125	7,822	0	34,880	1,482	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,558,545	130,785	76,800	456,188	38,273	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	564,395	37,936	0	223,385	9,494	52.00
53.00	05300	ANESTHESIOLOGY	89,863	4,195	6,246	0	31,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,180,261	81,685	55,899	341,774	73,446	54.00
57.00	05700	CT SCAN	321,661	4,738	3,579	53,797	86,705	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	221,096	14,044	131,001	38,177	36,970	58.00
60.00	06000	LABORATORY	1,825,046	42,362	7,238	270,374	75,500	60.00
65.00	06500	RESPIRATORY THERAPY	576,633	19,306	5,487	153,106	11,416	65.00
66.00	06600	PHYSICAL THERAPY	753,599	44,078	1,446	93,142	27,931	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	419,331	22,470	0	0	19,849	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	813,901	0	0	0	8,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	717,981	0	0	0	37,942	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	157,216	11,342	4,740	57,548	13,802	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	246,427	21,075	1,402	57,728	3,737	90.00
91.00	09100	EMERGENCY	2,251,819	70,859	25,118	462,857	58,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,885,407	1,430,740	420,570	4,330,043	560,106	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,057	8,346	119	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	470,769	130,705	247	57,508	0	192.00
194.00	07950	OTHER NONALLOWABLE	342,605	0	941	59,589	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	32,737,838	1,569,791	421,877	4,447,140	560,106	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	PATIENT ACCOUNTING	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.02	5A.02	5.03	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING	614,656					5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	7,582,431	7,582,431			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	402,522	121,330	523,852		6.00
7.00	00700	OPERATION OF PLANT	0	1,519,924	458,142	140,393	2,118,459	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,475	43,247	5,074	28,031	8.00
9.00	00900	HOUSEKEEPING	0	629,637	189,788	11,083	61,230	9.00
10.00	01000	DIETARY	0	202,395	61,007	30,057	166,051	10.00
11.00	01100	CAFETERIA	0	568,042	171,221	9,828	54,296	11.00
13.00	01300	NURSING ADMINISTRATION	0	416,659	125,591	3,662	20,232	13.00
15.00	01500	PHARMACY	0	750,918	226,345	6,266	34,615	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	532,218	160,423	6,439	35,572	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,763	2,897,523	873,383	66,932	369,773	30.00
43.00	04300	NURSERY	1,627	133,936	40,372	2,930	16,186	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,001	2,302,592	694,056	48,987	270,633	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,418	845,628	254,893	14,209	78,501	52.00
53.00	05300	ANESTHESIOLOGY	34,116	165,508	49,888	1,571	8,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,599	1,813,664	546,682	30,596	169,031	54.00
57.00	05700	CT SCAN	95,147	565,627	170,494	1,775	9,803	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	40,570	481,858	145,244	5,260	29,061	58.00
60.00	06000	LABORATORY	82,854	2,303,374	694,292	15,867	87,661	60.00
65.00	06500	RESPIRATORY THERAPY	12,528	778,476	234,651	7,231	39,949	65.00
66.00	06600	PHYSICAL THERAPY	30,652	950,848	286,608	16,510	91,210	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,782	483,432	145,718	8,416	46,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,807	832,644	250,979	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,637	797,560	240,404	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	15,146	259,794	78,308	4,248	23,469	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,101	334,470	100,817	7,894	43,610	90.00
91.00	09100	EMERGENCY	63,908	2,932,797	884,002	26,541	146,628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	614,656	31,627,952	7,247,885	471,769	1,830,720	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,522	14,324	3,126	17,271	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	659,229	198,707	48,957	270,468	192.00
194.00	07950	OTHER NONALLOWABLE	0	403,135	121,515	0	0	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	614,656	32,737,838	7,582,431	523,852	2,118,459	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	219,827					8.00
9.00	00900	HOUSEKEEPING	0	891,738				9.00
10.00	01000	DIETARY	82	0	459,592			10.00
11.00	01100	CAFETERIA	0	0	0	803,387		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,564	0	14,743	585,451	13.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	96,655	187,070	459,592	218,633	264,302	30.00
43.00	04300	NURSERY	9,846	5,317	0	7,051	8,524	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,738	135,128	0	108,734	131,446	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,155	55,001	0	45,102	54,523	52.00
53.00	05300	ANESTHESIOLOGY	0	10,351	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,283	71,610	0	80,939	0	54.00
57.00	05700	CT SCAN	5,193	8,657	0	11,596	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,244	0	0	7,808	0	58.00
60.00	06000	LABORATORY	4,521	40,839	0	71,266	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,113	0	36,187	0	65.00
66.00	06600	PHYSICAL THERAPY	4,968	29,171	0	39,450	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,034	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	44,745	0	26,164	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	58,013	0	13,053	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,281	7,340	0	17,889	0	90.00
91.00	09100	EMERGENCY	34,336	90,618	0	104,772	126,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	215,302	775,571	459,592	803,387	585,451	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,564	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,525	111,603	0	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	219,827	891,738	459,592	803,387	585,451	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	1,018,144					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	734,652				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	174,965	0	5,608,828	0	30.00
43.00	04300	NURSERY	0	8,272	0	232,434	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	108,185	0	3,828,499	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52,976	0	1,411,988	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	235,999	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,052	0	2,808,857	0	54.00
57.00	05700	CT SCAN	0	12,758	0	785,903	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,054	0	681,529	0	58.00
60.00	06000	LABORATORY	0	64,119	0	3,281,939	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	36,309	0	1,154,916	0	65.00
66.00	06600	PHYSICAL THERAPY	0	22,089	0	1,440,854	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	689,097	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,083,623	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,018,144	0	0	2,127,017	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	13,648	0	450,533	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	13,690	0	526,991	0	90.00
91.00	09100	EMERGENCY	0	109,766	0	4,456,116	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,018,144	706,883	0	30,805,123	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	86,807	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,638	0	1,307,127	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	14,131	0	538,781	0	194.00
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)	1,018,144	734,652	0	32,737,838	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,608,828		30.00
43.00	04300	NURSERY	232,434		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,828,499		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,411,988		52.00
53.00	05300	ANESTHESIOLOGY	235,999		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,808,857		54.00
57.00	05700	CT SCAN	785,903		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	681,529		58.00
60.00	06000	LABORATORY	3,281,939		60.00
65.00	06500	RESPIRATORY THERAPY	1,154,916		65.00
66.00	06600	PHYSICAL THERAPY	1,440,854		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	689,097		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,083,623		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,127,017		73.00
76.00	03020	OTHER	0		76.00
76.97	07697	CARDIAC REHABILITATION	450,533		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	526,991		90.00
91.00	09100	EMERGENCY	4,456,116		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,805,123		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	86,807		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,307,127		192.00
194.00	07950	OTHER NONALLOWABLE	538,781		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	32,737,838		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,671	0	5,671	5,671	4.00
5.01	00570	ADMITTING	0	26,452	0	26,452	187	5.01
5.02	00540	PATIENT ACCOUNTING	0	2,053	0	2,053	4	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	399	137,051	57,107	194,557	681	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	139	6.00
7.00	00700	OPERATION OF PLANT	1,404	374,807	0	376,211	34	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,546	0	13,546	0	8.00
9.00	00900	HOUSEKEEPING	0	29,590	409	29,999	145	9.00
10.00	01000	DIETARY	0	80,245	4,254	84,499	32	10.00
11.00	01100	CAFETERIA	0	26,239	0	26,239	145	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,777	7,306	17,083	136	13.00
15.00	01500	PHARMACY	84,175	16,728	6,336	107,239	215	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,190	0	17,190	2	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	178,694	26,202	204,896	941	30.00
43.00	04300	NURSERY	0	7,822	0	7,822	44	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	743	130,785	76,800	208,328	582	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	37,936	0	37,936	285	52.00
53.00	05300	ANESTHESIOLOGY	1,134	4,195	6,246	11,575	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,685	55,899	137,584	436	54.00
57.00	05700	CT SCAN	0	4,738	3,579	8,317	69	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,044	131,001	145,045	49	58.00
60.00	06000	LABORATORY	79,411	42,362	7,238	129,011	345	60.00
65.00	06500	RESPIRATORY THERAPY	16,375	19,306	5,487	41,168	195	65.00
66.00	06600	PHYSICAL THERAPY	0	44,078	1,446	45,524	119	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,366	22,470	0	28,836	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	11,342	4,740	16,082	73	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	21,075	1,402	22,477	74	90.00
91.00	09100	EMERGENCY	0	70,859	25,118	95,977	590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	190,007	1,430,740	420,570	2,041,317	5,522	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	124	8,346	119	8,589	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	130,705	247	130,952	73	192.00
194.00	07950	OTHER NONALLOWABLE	6,600	0	941	7,541	76	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	196,731	1,569,791	421,877	2,188,399	5,671	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	ADMITTING	PATIENT ACCOUNTING	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			5.01	5.02	5.03	6.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	26,639					5.01
5.02	00540	PATIENT ACCOUNTING	0	2,057				5.02
5.03	00550	ADMINISTRATIVE & GENERAL	0	0	195,238			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	3,124	3,263		6.00
7.00	00700	OPERATION OF PLANT	0	0	11,796	875	388,916	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,114	32	5,146	8.00
9.00	00900	HOUSEKEEPING	0	0	4,887	69	11,241	9.00
10.00	01000	DIETARY	0	0	1,571	187	30,484	10.00
11.00	01100	CAFETERIA	0	0	4,409	61	9,968	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	3,234	23	3,714	13.00
15.00	01500	PHARMACY	0	0	5,828	39	6,355	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4,131	40	6,530	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,203	91	22,488	417	67,884	30.00
43.00	04300	NURSERY	71	5	1,039	18	2,971	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,820	137	17,870	305	49,684	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	452	34	6,563	89	14,412	52.00
53.00	05300	ANESTHESIOLOGY	1,479	111	1,285	10	1,594	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,493	263	14,076	191	31,031	54.00
57.00	05700	CT SCAN	4,122	361	4,390	11	1,800	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,758	133	3,740	33	5,335	58.00
60.00	06000	LABORATORY	3,591	271	17,876	99	16,093	60.00
65.00	06500	RESPIRATORY THERAPY	543	41	6,042	45	7,334	65.00
66.00	06600	PHYSICAL THERAPY	1,329	100	7,380	103	16,745	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	944	71	3,752	52	8,536	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	425	32	6,462	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,805	136	6,190	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	656	49	2,016	26	4,309	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	178	13	2,596	49	8,006	90.00
91.00	09100	EMERGENCY	2,770	209	22,765	165	26,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,639	2,057	186,624	2,939	336,091	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	369	19	3,171	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,116	305	49,654	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	3,129	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	26,639	2,057	195,238	3,263	388,916	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,838					8.00
9.00	00900	HOUSEKEEPING	0	46,341				9.00
10.00	01000	DIETARY	7	0	116,780			10.00
11.00	01100	CAFETERIA	0	0	0	40,822		11.00
13.00	01300	NURSING ADMINISTRATION	0	237	0	749	25,176	13.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,722	9,723	116,780	11,109	11,364	30.00
43.00	04300	NURSERY	889	276	0	358	367	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,593	7,022	0	5,525	5,653	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,007	2,858	0	2,292	2,345	52.00
53.00	05300	ANESTHESIOLOGY	0	538	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379	3,721	0	4,113	0	54.00
57.00	05700	CT SCAN	469	450	0	589	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	293	0	0	397	0	58.00
60.00	06000	LABORATORY	408	2,122	0	3,621	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,149	0	1,839	0	65.00
66.00	06600	PHYSICAL THERAPY	448	1,516	0	2,005	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	262	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,325	0	1,329	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,015	0	663	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	116	381	0	909	0	90.00
91.00	09100	EMERGENCY	3,099	4,709	0	5,324	5,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,430	40,304	116,780	40,822	25,176	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	237	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	408	5,800	0	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,838	46,341	116,780	40,822	25,176	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY	119,676					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,893				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,644	0	462,262	0	30.00
43.00	04300	NURSERY	0	314	0	14,174	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,107	0	303,626	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,011	0	70,284	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,592	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,077	0	199,364	0	54.00
57.00	05700	CT SCAN	0	484	0	21,062	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	344	0	157,127	0	58.00
60.00	06000	LABORATORY	0	2,434	0	175,871	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,379	0	59,735	0	65.00
66.00	06600	PHYSICAL THERAPY	0	839	0	76,108	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	42,453	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,919	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,676	0	0	131,461	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	518	0	27,407	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	520	0	35,319	0	90.00
91.00	09100	EMERGENCY	0	4,167	0	172,141	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,676	26,838	0	1,971,905	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12,385	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	518	0	192,826	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	537	0	11,283	0	194.00
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)	119,676	27,893	0	2,188,399	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00570	ADMITTING			5.01
5.02	00540	PATIENT ACCOUNTING			5.02
5.03	00550	ADMINISTRATIVE & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	462,262		30.00
43.00	04300	NURSERY	14,174		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	303,626		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,284		52.00
53.00	05300	ANESTHESIOLOGY	16,592		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199,364		54.00
57.00	05700	CT SCAN	21,062		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	157,127		58.00
60.00	06000	LABORATORY	175,871		60.00
65.00	06500	RESPIRATORY THERAPY	59,735		65.00
66.00	06600	PHYSICAL THERAPY	76,108		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,453		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,919		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,461		73.00
76.00	03020	OTHER	0		76.00
76.97	07697	CARDIAC REHABILITATION	27,407		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	35,319		90.00
91.00	09100	EMERGENCY	172,141		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,971,905		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,385		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192,826		192.00
194.00	07950	OTHER NONALLOWABLE	11,283		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,188,399		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS REVENUES)	PATIENT ACCOUNTING (GROSS REVENUES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	176,610					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,232,713				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	638	0	10,717,662			4.00
5.01	00570	ADMITTING	2,976	0	353,800	105,714,420		5.01
5.02	00540	PATIENT ACCOUNTING	231	0	8,404	0	105,714,420	5.02
5.03	00550	ADMINISTRATIVE & GENERAL	15,419	166,866	1,286,447	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	263,374	0	0	6.00
7.00	00700	OPERATION OF PLANT	42,168	0	64,457	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,524	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,329	1,196	274,423	0	0	9.00
10.00	01000	DIETARY	9,028	12,430	59,671	0	0	10.00
11.00	01100	CAFETERIA	2,952	0	274,106	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,100	21,348	256,313	0	0	13.00
15.00	01500	PHARMACY	1,882	18,515	406,746	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,934	0	4,066	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,104	76,562	1,778,103	4,775,237	4,775,237	30.00
43.00	04300	NURSERY	880	0	84,060	279,800	279,800	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,714	224,408	1,099,417	7,224,053	7,224,053	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,268	0	538,360	1,791,961	1,791,961	52.00
53.00	05300	ANESTHESIOLOGY	472	18,250	0	5,867,856	5,867,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,190	163,334	823,680	13,862,902	13,862,902	54.00
57.00	05700	CT SCAN	533	10,459	129,652	16,359,910	16,359,910	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,580	382,777	92,007	6,978,020	6,978,020	58.00
60.00	06000	LABORATORY	4,766	21,150	651,604	14,250,749	14,250,749	60.00
65.00	06500	RESPIRATORY THERAPY	2,172	16,034	368,987	2,154,717	2,154,717	65.00
66.00	06600	PHYSICAL THERAPY	4,959	4,226	224,474	5,272,052	5,272,052	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,528	0	0	3,746,488	3,746,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,686,748	1,686,748	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,161,557	7,161,557	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,276	13,850	138,692	2,605,061	2,605,061	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,371	4,096	139,125	705,303	705,303	90.00
91.00	09100	EMERGENCY	7,972	73,394	1,115,489	10,992,006	10,992,006	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	160,966	1,228,895	10,435,457	105,714,420	105,714,420	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	939	348	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,705	721	138,596	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	2,749	143,609	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,569,791	421,877	4,447,140	560,106	614,656	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.888460	0.342235	0.414936	0.005298	0.005814	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,671	26,639	2,057	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000529	0.000252	0.000019	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A.03	5.03	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL	-7,582,431	25,155,407				5.03
6.00	00600	MAINTENANCE & REPAIRS	0	402,522	157,346			6.00
7.00	00700	OPERATION OF PLANT	0	1,519,924	42,168	115,178		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,475	1,524	1,524	210,262	8.00
9.00	00900	HOUSEKEEPING	0	629,637	3,329	3,329	0	9.00
10.00	01000	DIETARY	0	202,395	9,028	9,028	78	10.00
11.00	01100	CAFETERIA	0	568,042	2,952	2,952	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	416,659	1,100	1,100	0	13.00
15.00	01500	PHARMACY	0	750,918	1,882	1,882	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	532,218	1,934	1,934	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,897,523	20,104	20,104	92,449	30.00
43.00	04300	NURSERY	0	133,936	880	880	9,418	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,302,592	14,714	14,714	27,488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	845,628	4,268	4,268	10,670	52.00
53.00	05300	ANESTHESIOLOGY	0	165,508	472	472	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,813,664	9,190	9,190	14,618	54.00
57.00	05700	CT SCAN	0	565,627	533	533	4,967	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	481,858	1,580	1,580	3,103	58.00
60.00	06000	LABORATORY	0	2,303,374	4,766	4,766	4,324	60.00
65.00	06500	RESPIRATORY THERAPY	0	778,476	2,172	2,172	0	65.00
66.00	06600	PHYSICAL THERAPY	0	950,848	4,959	4,959	4,752	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	483,432	2,528	2,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	832,644	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	797,560	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	259,794	1,276	1,276	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	334,470	2,371	2,371	1,225	90.00
91.00	09100	EMERGENCY	0	2,932,797	7,972	7,972	32,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,582,431	24,045,521	141,702	99,534	205,934	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,522	939	939	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	659,229	14,705	14,705	4,328	192.00
194.00	07950	OTHER NONALLOWABLE	0	403,135	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		7,582,431	523,852	2,118,459	219,827	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.301424	3.329300	18.392914	1.045491	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		195,238	3,263	388,916	19,838	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007761	0.020738	3.376652	0.094349	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00540	PATIENT ACCOUNTING						5.02
5.03	00550	ADMINISTRATIVE & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	18,953					9.00
10.00	01000	DIETARY	0	26,878				10.00
11.00	01100	CAFETERIA	0	0	13,787			11.00
13.00	01300	NURSING ADMINISTRATION	97	0	253	8,311		13.00
15.00	01500	PHARMACY	0	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,976	26,878	3,752	3,752	0	30.00
43.00	04300	NURSERY	113	0	121	121	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,872	0	1,866	1,866	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,169	0	774	774	0	52.00
53.00	05300	ANESTHESIOLOGY	220	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,522	0	1,389	0	0	54.00
57.00	05700	CT SCAN	184	0	199	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	134	0	0	58.00
60.00	06000	LABORATORY	868	0	1,223	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	470	0	621	0	0	65.00
66.00	06600	PHYSICAL THERAPY	620	0	677	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	107	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	951	0	449	0	100	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,233	0	224	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	156	0	307	0	0	90.00
91.00	09100	EMERGENCY	1,926	0	1,798	1,798	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,484	26,878	13,787	8,311	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	97	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,372	0	0	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	891,738	459,592	803,387	585,451	1,018,144	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.049966	17.099189	58.271343	70.442907	10,181.440000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,341	116,780	40,822	25,176	119,676	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.445048	4.344817	2.960905	3.029238	1,196.760000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/28/2016 4:11 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS SALARIES)	SOCIAL SERVICE (TIME SPENT)		
			16.00	17.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00570	ADMITTING				5.01
5.02	00540	PATIENT ACCOUNTING				5.02
5.03	00550	ADMINISTRATIVE & GENERAL				5.03
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,465,855			16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,778,103	0		30.00
43.00	04300	NURSERY	84,060	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,099,417	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	538,360	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	823,680	0		54.00
57.00	05700	CT SCAN	129,652	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	92,007	0		58.00
60.00	06000	LABORATORY	651,604	0		60.00
65.00	06500	RESPIRATORY THERAPY	368,987	0		65.00
66.00	06600	PHYSICAL THERAPY	224,474	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	138,692	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	139,125	0		90.00
91.00	09100	EMERGENCY	1,115,489	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,183,650	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	138,596	0		192.00
194.00	07950	OTHER NONALLOWABLE	143,609	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	734,652	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.098402	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,893	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003736	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 4:11 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	5,608,828		5,608,828	0	0	30.00
43.00	04300	NURSERY	232,434		232,434	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,828,499		3,828,499	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,411,988		1,411,988	0	0	52.00
53.00	05300	ANESTHESIOLOGY	235,999		235,999	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,808,857		2,808,857	0	0	54.00
57.00	05700	CT SCAN	785,903		785,903	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	681,529		681,529	0	0	58.00
60.00	06000	LABORATORY	3,281,939		3,281,939	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,154,916	0	1,154,916	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,440,854	0	1,440,854	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	689,097		689,097	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,083,623		1,083,623	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,127,017		2,127,017	0	0	73.00
76.00	03020	OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	450,533		450,533	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	526,991		526,991	0	0	90.00
91.00	09100	EMERGENCY	4,456,116		4,456,116	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	536,451		536,451		0	92.00
200.00		Subtotal (see instructions)	31,341,574	0	31,341,574	0	0	200.00
201.00		Less Observation Beds	536,451		536,451		0	201.00
202.00		Total (see instructions)	30,805,123	0	30,805,123	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 4:11 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	4,080,049		4,080,049			30.00
43.00	04300	NURSERY	279,800		279,800			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,127,380	6,096,673	7,224,053	0.529966	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	878,359	913,602	1,791,961	0.787957	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,076,852	4,791,004	5,867,856	0.040219	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,180,206	12,682,696	13,862,902	0.202617	0.000000	54.00
57.00	05700	CT SCAN	1,688,281	14,671,629	16,359,910	0.048038	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	271,741	6,706,279	6,978,020	0.097668	0.000000	58.00
60.00	06000	LABORATORY	3,645,190	10,605,559	14,250,749	0.230299	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	422,388	1,732,329	2,154,717	0.535994	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,324,499	3,947,553	5,272,052	0.273300	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,797,211	1,949,277	3,746,488	0.183931	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,307,577	379,171	1,686,748	0.642433	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,008,187	4,153,370	7,161,557	0.297005	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	261,640	2,343,421	2,605,061	0.172945	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	730	704,573	705,303	0.747184	0.000000	90.00
91.00	09100	EMERGENCY	1,321,193	9,670,813	10,992,006	0.405396	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	695,188	695,188	0.771663	0.000000	92.00
200.00		Subtotal (see instructions)	23,671,283	82,043,137	105,714,420			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,671,283	82,043,137	105,714,420			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 4:11 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		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
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 4:11 pm

Title XIX | 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	5,608,828		5,608,828	0	5,608,828	30.00
43.00	04300	NURSERY	232,434		232,434	0	232,434	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,828,499		3,828,499	0	3,828,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,411,988		1,411,988	0	1,411,988	52.00
53.00	05300	ANESTHESIOLOGY	235,999		235,999	0	235,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,808,857		2,808,857	0	2,808,857	54.00
57.00	05700	CT SCAN	785,903		785,903	0	785,903	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	681,529		681,529	0	681,529	58.00
60.00	06000	LABORATORY	3,281,939		3,281,939	0	3,281,939	60.00
65.00	06500	RESPIRATORY THERAPY	1,154,916	0	1,154,916	0	1,154,916	65.00
66.00	06600	PHYSICAL THERAPY	1,440,854	0	1,440,854	0	1,440,854	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	689,097		689,097	0	689,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,083,623		1,083,623	0	1,083,623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,127,017		2,127,017	0	2,127,017	73.00
76.00	03020	OTHER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	450,533		450,533	0	450,533	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	526,991		526,991	0	526,991	90.00
91.00	09100	EMERGENCY	4,456,116		4,456,116	0	4,456,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	536,451		536,451		536,451	92.00
200.00		Subtotal (see instructions)	31,341,574	0	31,341,574	0	31,341,574	200.00
201.00		Less Observation Beds	536,451		536,451		536,451	201.00
202.00		Total (see instructions)	30,805,123	0	30,805,123	0	30,805,123	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 4:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,080,049		4,080,049			30.00
43.00	04300	NURSERY	279,800		279,800			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,127,380	6,096,673	7,224,053	0.529966	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	878,359	913,602	1,791,961	0.787957	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,076,852	4,791,004	5,867,856	0.040219	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,180,206	12,682,696	13,862,902	0.202617	0.000000	54.00
57.00	05700	CT SCAN	1,688,281	14,671,629	16,359,910	0.048038	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	271,741	6,706,279	6,978,020	0.097668	0.000000	58.00
60.00	06000	LABORATORY	3,645,190	10,605,559	14,250,749	0.230299	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	422,388	1,732,329	2,154,717	0.535994	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,324,499	3,947,553	5,272,052	0.273300	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,797,211	1,949,277	3,746,488	0.183931	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,307,577	379,171	1,686,748	0.642433	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,008,187	4,153,370	7,161,557	0.297005	0.000000	73.00
76.00	03020	OTHER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	261,640	2,343,421	2,605,061	0.172945	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	730	704,573	705,303	0.747184	0.000000	90.00
91.00	09100	EMERGENCY	1,321,193	9,670,813	10,992,006	0.405396	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	695,188	695,188	0.771663	0.000000	92.00
200.00		Subtotal (see instructions)	23,671,283	82,043,137	105,714,420			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	23,671,283	82,043,137	105,714,420			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/28/2016 4:11 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OTHER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		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
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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/28/2016 4:11 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	303,626	7,224,053	0.042030	595,787	25,041	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	70,284	1,791,961	0.039222	0	0	52.00
53.00	05300	ANESTHESIOLOGY	16,592	5,867,856	0.002828	436,856	1,235	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199,364	13,862,902	0.014381	760,497	10,937	54.00
57.00	05700	CT SCAN	21,062	16,359,910	0.001287	476,923	614	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	157,127	6,978,020	0.022517	197,250	4,441	58.00
60.00	06000	LABORATORY	175,871	14,250,749	0.012341	1,564,173	19,303	60.00
65.00	06500	RESPIRATORY THERAPY	59,735	2,154,717	0.027723	322,057	8,928	65.00
66.00	06600	PHYSICAL THERAPY	76,108	5,272,052	0.014436	562,751	8,124	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,453	3,746,488	0.011331	908,345	10,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,919	1,686,748	0.004102	744,653	3,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,461	7,161,557	0.018356	1,269,858	23,310	73.00
76.00	03020	OTHER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	27,407	2,605,061	0.010521	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,319	705,303	0.050076	0	0	90.00
91.00	09100	EMERGENCY	172,141	10,992,006	0.015661	69,806	1,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	44,213	695,188	0.063599	0	0	92.00
200.00		Total (lines 50-199)	1,539,682	101,354,571		7,908,956	116,373	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 4:11 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/28/2016 4:11 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	7,224,053	0.000000	0.000000	595,787	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,791,961	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,867,856	0.000000	0.000000	436,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,862,902	0.000000	0.000000	760,497	54.00
57.00	05700	CT SCAN	0	16,359,910	0.000000	0.000000	476,923	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,978,020	0.000000	0.000000	197,250	58.00
60.00	06000	LABORATORY	0	14,250,749	0.000000	0.000000	1,564,173	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,154,717	0.000000	0.000000	322,057	65.00
66.00	06600	PHYSICAL THERAPY	0	5,272,052	0.000000	0.000000	562,751	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,746,488	0.000000	0.000000	908,345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,686,748	0.000000	0.000000	744,653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,161,557	0.000000	0.000000	1,269,858	73.00
76.00	03020	OTHER	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	2,605,061	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	705,303	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	10,992,006	0.000000	0.000000	69,806	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	695,188	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	101,354,571			7,908,956	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/28/2016 4:11 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OTHER	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/28/2016 4:11 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	0.529966	0	2,015,050	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.787957	0	1,889	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040219	0	1,149,021	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202617	0	5,960,678	0	0	54.00
57.00	05700	CT SCAN	0.048038	0	6,286,695	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.097668	0	2,201,760	0	0	58.00
60.00	06000	LABORATORY	0.230299	0	4,447,462	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.535994	0	631,872	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.273300	0	1,204,207	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.183931	0	749,368	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.642433	0	97,706	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.297005	0	2,082,145	1,326	0	73.00
76.00	03020	OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.172945	0	263,870	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.747184	0	257,707	0	0	90.00
91.00	09100	EMERGENCY	0.405396	0	3,793,414	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.771663	0	497,406	0	0	92.00
200.00		Subtotal (see instructions)		0	31,640,250	1,326	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	31,640,250	1,326	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/28/2016 4:11 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	1,067,908	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,488	0		52.00
53.00	05300	ANESTHESIOLOGY	46,212	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,207,735	0		54.00
57.00	05700	CT SCAN	302,000	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	215,041	0		58.00
60.00	06000	LABORATORY	1,024,246	0		60.00
65.00	06500	RESPIRATORY THERAPY	338,680	0		65.00
66.00	06600	PHYSICAL THERAPY	329,110	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	137,832	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,770	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	618,407	394		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	45,635	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	192,555	0		90.00
91.00	09100	EMERGENCY	1,537,835	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	383,830	0		92.00
200.00		Subtotal (see instructions)	7,511,284	394		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,511,284	394		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141350 | Component CCN: 14Z350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/28/2016 4:11 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	0.529966	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.787957	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040219	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202617	0	0	0	0	54.00
57.00	05700	CT SCAN	0.048038	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.097668	0	0	0	0	58.00
60.00	06000	LABORATORY	0.230299	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.535994	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.273300	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.183931	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.642433	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.297005	0	0	0	0	73.00
76.00	03020	OTHER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.172945	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.747184	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.405396	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.771663	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: 141350 | Component CCN: 14Z350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V | Date/Time Prepared: 11/28/2016 4:11 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OTHER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/28/2016 4:11 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)	5,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,777	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,243	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	392	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)	393	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	72	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)	73	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,859	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)	392	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)	393	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)	5,608,828	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)	10,340	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)	10,961	25.00
26.00	Total swing-bed cost (see instructions)	809,904	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,798,924	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)	4,798,924	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,004.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,872,123	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)	2,872,123	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/28/2016 4:11 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	2,267,146	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,139,269	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)	393,799	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	394,804	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	788,603	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)	534	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,004.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	536,451	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/28/2016 4:11 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	462,262	5,608,828	0.082417	536,451	44,213	90.00
91.00	Nursing School cost	0	5,608,828	0.000000	536,451	0	91.00
92.00	Allied health cost	0	5,608,828	0.000000	536,451	0	92.00
93.00	All other Medical Education	0	5,608,828	0.000000	536,451	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 4:11 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		2,377,163		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.529966	595,787	315,747	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.787957	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040219	436,856	17,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202617	760,497	154,090	54.00
57.00	05700	CT SCAN	0.048038	476,923	22,910	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.097668	197,250	19,265	58.00
60.00	06000	LABORATORY	0.230299	1,564,173	360,227	60.00
65.00	06500	RESPIRATORY THERAPY	0.535994	322,057	172,621	65.00
66.00	06600	PHYSICAL THERAPY	0.273300	562,751	153,800	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.183931	908,345	167,073	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.642433	744,653	478,390	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.297005	1,269,858	377,154	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.172945	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.747184	0	0	90.00
91.00	09100	EMERGENCY	0.405396	69,806	28,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.771663	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		7,908,956	2,267,146	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)		7,908,956		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141350 | Component CCN: 14Z350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 4:11 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.529966	1,417	751	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.787957	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040219	3,397	137	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202617	29,389	5,955	54.00
57.00	05700	CT SCAN	0.048038	11,321	544	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.097668	0	0	58.00
60.00	06000	LABORATORY	0.230299	147,501	33,969	60.00
65.00	06500	RESPIRATORY THERAPY	0.535994	33,576	17,997	65.00
66.00	06600	PHYSICAL THERAPY	0.273300	457,240	124,964	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.183931	114,579	21,075	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.642433	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.297005	198,556	58,972	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.172945	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.747184	0	0	90.00
91.00	09100	EMERGENCY	0.405396	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.771663	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		996,976	264,364	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)		996,976		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141350 | Component CCN: 14Z350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/28/2016 4:11 pm

Title XIX | 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
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.529966	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.787957	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.040219	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.202617	0	0	54.00
57.00	05700	CT SCAN	0.048038	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.097668	0	0	58.00
60.00	06000	LABORATORY	0.230299	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.535994	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.273300	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.183931	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.642433	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.297005	0	0	73.00
76.00	03020	OTHER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.172945	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.747184	0	0	90.00
91.00	09100	EMERGENCY	0.405396	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.771663	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141350	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/28/2016 4:11 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,511,678	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)	7,511,678	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)	7,586,795	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)	58,412	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,456,784	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)	2,071,599	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)	2,071,599	30.00
31.00	Primary payer payments	391	31.00
32.00	Subtotal (line 30 minus line 31)	2,071,208	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)	870,356	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	565,731	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	496,386	36.00
37.00	Subtotal (see instructions)	2,636,939	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)	2,636,939	40.00
40.01	Sequestration adjustment (see instructions)	52,739	40.01
41.00	Interim payments	2,178,416	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	405,784	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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2016 4:11 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,914,456		2,646,499	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	03/24/2016	18,759		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	12/17/2015	72,069	12/17/2015	354,439	3.50
3.51			0	03/24/2016	113,644	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)		-53,310		-468,083	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)		3,861,146		2,178,416	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		589,285		405,784	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,450,431		2,584,200	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: 141350 | Component CCN: 14Z350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/28/2016 4:11 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		987,486		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/17/2015	68,431		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)		-68,431		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)		919,055		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		114,723		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,033,778		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: 141350	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/28/2016 4:11 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	1,375	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,859	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	209	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,243	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	105,714,420	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,913,243	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141350 Component CCN: 14Z350	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2 Date/Time Prepared: 11/28/2016 4:11 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)	796,489	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)	267,008	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	785	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)	1,063,497	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,063,497	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)	1,063,497	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,621	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)	1,054,876	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)	1,054,876	0	19.00
19.01	Sequestration adjustment (see instructions)	21,098	0	19.01
20.00	Interim payments	919,055	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)	114,723	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 - SWING BEDS

Provider CCN: 141350 | Component CCN: 14Z350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-2 | Date/Time Prepared: 11/28/2016 4:11 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141350	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/28/2016 4:11 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,139,269	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)	5,139,269	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,190,662	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)	5,190,662	19.00
20.00	Deductibles (exclude professional component)	682,897	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,507,765	22.00
23.00	Coinsurance	7,028	23.00
24.00	Subtotal (line 22 minus line 23)	4,500,737	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	62,337	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	40,519	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,772	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,541,256	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	4,541,256	30.00
30.01	Sequestration adjustment (see instructions)	90,825	30.01
31.00	Interim payments	3,861,146	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)	589,285	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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/28/2016 4:11 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	4,768,431	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	22,498,400	0	0	0	4.00
5.00	Other receivable	195,302	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-16,794,910	0	0	0	6.00
7.00	Inventory	366,750	0	0	0	7.00
8.00	Prepaid expenses	196,674	0	0	0	8.00
9.00	Other current assets	3,286,738	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)	14,517,385	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	99,383	0	0	0	12.00
13.00	Land improvements	1,836,116	0	0	0	13.00
14.00	Accumulated depreciation	-1,241,461	0	0	0	14.00
15.00	Buildings	11,373,963	0	0	0	15.00
16.00	Accumulated depreciation	-5,091,066	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	23,817,534	0	0	0	19.00
20.00	Accumulated depreciation	-11,468,147	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	20,718,534	0	0	0	23.00
24.00	Accumulated depreciation	-16,529,900	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)	23,514,956	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	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	34,626,394	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,626,394	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	72,658,735	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	996,800	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	4,278,750	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	22,264,601	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	27,540,151	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	27,540,151	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	45,118,584				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)	45,118,584	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	72,658,735	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/28/2016 4:11 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		43,338,179		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,990,367				2.00
3.00	Total (sum of line 1 and line 2)		45,328,546		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		45,328,546		0		11.00
12.00	OTHER CHANGES IN NET ASSETS	209,962		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)		209,962		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		45,118,584		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	OTHER CHANGES 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: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/28/2016 4:11 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,390,867		4,390,867	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,390,867		4,390,867	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	4,390,867		4,390,867	17.00
18.00	Ancillary services	19,367,569	83,302,248	102,669,817	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	44,498	179,666	224,164	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,802,934	83,481,914	107,284,848	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,682,701		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)		40,682,701		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141350 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-3 | Date/Time Prepared: 11/28/2016 4:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	107,284,848	1.00
2.00	Less contractual allowances and discounts on patients' accounts	65,445,839	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,839,009	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,682,701	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,156,308	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	2,090,201	24.00
25.00	Total other income (sum of lines 6-24)	2,090,201	25.00
26.00	Total (line 5 plus line 25)	3,246,509	26.00
27.00	NON-OPERATING EXPENSES	1,256,142	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	1,256,142	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,990,367	29.00