

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/30/2016 1:46 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/30/2016 Time: 1:46 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. ANTHONYS MEMORIAL HOSPITAL (140032) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	120,146	116,910	4,562	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	120,146	116,910	4,562	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/30/2016 1:46 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 503 N MAPLE			PO Box:				1.00				
2.00	City: EFFINGHAM			State: IL		Zip Code: 62401		County: EFFINGHAM			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		ST. ANTHONYS MEMORIAL HOSPITAL		140032	41180	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											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		ST. ANTHONYS MEMORIAL HOSPITAL HHA		147661	41180		02/17/1997	N	P	N	12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - 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.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							2		N	23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,138	648	0	0	19	82		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/30/2016 1:46 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		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.		0				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.		N				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	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.		N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)		N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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
	Program Name		Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ col. 1 + col. 2))	
	1.00	2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				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.			N		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 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00		
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.			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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
						1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.	N				110.00
						1.00 2.00 3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0		118.01
						1.00 2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/30/2016 1:46 pm			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				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:		Contractor's Number:		141.00	
142.00	Street: 4936 LAVERNA ROAD	PO Box:				142.00	
143.00	City: SPRINGFIELD IL 62707	State:		Zip Code:		143.00	
					1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00	
					1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
					1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00	
				Part A	Part B	Title V	Title XIX
				1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	N	157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00
161.00	CMHC		N	N	N	N	161.00
							1.00
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N				165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.25
							169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/30/2016 1:46 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		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. 1, 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: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/30/2016 1:46 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			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	11/22/2016	Y	11/22/2016
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	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/30/2016 1:46 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2016 1:46 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					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	123	45,018	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		123	45,018	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,660	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		133	48,678	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		133				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: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2016 1:46 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,860	1,389	14,432			1.00
2.00 HMO and other (see instructions)	267	646				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	8,860	1,389	14,432			7.00
8.00 INTENSIVE CARE UNIT	1,137	158	1,700			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		612	1,491			13.00
14.00 Total (see instructions)	9,997	2,159	17,623	0.00	622.43	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	34,045	2,076	62,880	0.00	45.38	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	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	667.81	27.00
28.00 Observation Bed Days		370	1,907			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			275			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	82	148			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: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2016 1:46 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,674	656	5,158	1.00
2.00 HMO and other (see instructions)			75	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,674	656	5,158	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					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 WAGE INDEX INFORMATION			Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part II Date/Time Prepared: 11/30/2016 1:46 pm			
	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	40,131,063	0	40,131,063	1,389,043.69	28.89	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,060,141	0	6,060,141	132,034.08	45.90	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		2,436,563	0	2,436,563	35,863.52	67.94	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		4,544,108	0	4,544,108	64,207.40	70.77	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		12,877,388	0	12,877,388			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,693,305	0	1,693,305			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	3,571	-2,154	1,417	108.59	13.05	26.00
27.00	Administrative & General	5.00	5,135,559	2,154	5,137,713	195,196.64	26.32	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	827,649	0	827,649	35,687.32	23.19	30.00
31.00	Laundry & Linen Service	8.00	70,568	0	70,568	5,123.37	13.77	31.00
32.00	Housekeeping	9.00	646,564	0	646,564	52,952.74	12.21	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	759,690	-452,495	307,195	16,164.76	19.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	57,624	452,495	510,119	36,272.95	14.06	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	935,309	0	935,309	23,151.42	40.40	38.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part II
Date/Time Prepared:
11/30/2016 1:46 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
39.00	Central Services and Supply	14.00	16,004	0	16,004	852.33	18.78	39.00
40.00	Pharmacy	15.00	1,224,056	0	1,224,056	29,330.86	41.73	40.00
41.00	Medical Records & Medical Records Library	16.00	2,360,325	0	2,360,325	75,478.90	31.27	41.00
42.00	Social Service	17.00	48	0	48	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part III
Date/Time Prepared:
11/30/2016 1:46 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	40,131,063	0	40,131,063	1,389,043.69	28.89	1.00
2.00	Excluded area salaries (see instructions)	6,060,141	0	6,060,141	132,034.08	45.90	2.00
3.00	Subtotal salaries (line 1 minus line 2)	34,070,922	0	34,070,922	1,257,009.61	27.10	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,980,671	0	6,980,671	100,070.92	69.76	4.00
5.00	Subtotal wage-related costs (see inst.)	12,877,388	0	12,877,388	0.00	37.80	5.00
6.00	Total (sum of lines 3 thru 5)	53,928,981	0	53,928,981	1,357,080.53	39.74	6.00
7.00	Total overhead cost (see instructions)	12,036,967	0	12,036,967	470,319.88	25.59	7.00

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	125,328	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	2,720,500	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	8,345,742	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	648,023	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,069,021	17.00
18.00	Medicare Taxes - Employers Portion Only	581,901	18.00
19.00	Unemployment Insurance	13,106	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	67,072	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	14,570,693	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part V Date/Time Prepared: 11/30/2016 1:46 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140032 Component CCN: 147661		Period: From 07/01/2015 To 06/30/2016		Worksheet S-4 Date/Time Prepared: 11/30/2016 1:46 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			EFFINGHAM		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	9,575	210	1,370	11,155	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,072.00	147.00	302.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
				Staff	Contract	Total	
		Enter the number of hours in your normal work week					
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			7.34	0.00	7.34	5.00
6.00	Direct Nursing Service			28.84	0.00	28.84	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			3.50	0.00	3.50	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.66	0.00	2.66	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.30	0.00	0.30	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.78	0.00	0.78	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.96	0.00	1.96	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			41180			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (col s. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	15,498	3,307	300	349	19,454	21.00
22.00	Skilled Nursing Visit Charges	3,342,984	712,389	61,081	75,213	4,191,667	22.00
23.00	Physical Therapy Visits	7,306	311	37	195	7,849	23.00
24.00	Physical Therapy Visit Charges	1,677,203	71,346	6,886	44,847	1,800,282	24.00
25.00	Occupational Therapy Visits	2,723	199	15	72	3,009	25.00
26.00	Occupational Therapy Visit Charges	624,690	45,650	2,079	16,621	689,040	26.00
27.00	Speech Pathology Visits	230	87	4	1	322	27.00
28.00	Speech Pathology Visit Charges	52,558	19,998	924	231	73,711	28.00
29.00	Medical Social Service Visits	244	25	3	8	280	29.00
30.00	Medical Social Service Visit Charges	69,537	7,150	572	2,288	79,547	30.00
31.00	Home Health Aide Visits	2,479	599	5	48	3,131	31.00
32.00	Home Health Aide Visit Charges	258,045	62,485	315	5,040	325,885	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	28,480	4,528	364	673	34,045	33.00
34.00	Other Charges	98,993	45,762	1,938	1,608	148,301	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	6,124,010	964,780	73,795	145,848	7,308,433	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,628		108	46	1,782	36.00
37.00	Total Number of Outlier Episodes		103		6	109	37.00
38.00	Total Non-Routine Medical Supply Charges	40,522	16,809	1,103	838	59,272	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10	Date/Time Prepared: 11/30/2016 1:46 pm
					1.00
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.318272	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			8,539,294	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			60,667,919	6.00
7.00	Medicaid cost (line 1 times line 6)			19,308,900	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)			10,769,606	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			10,769,606	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	2,406,338	6,997,286	9,403,624	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	765,870	2,227,040	2,992,910	21.00
22.00	Partial payment by patients approved for charity care	83,757	89,160	172,917	22.00
23.00	Cost of charity care (line 21 minus line 22)	682,113	2,137,880	2,819,993	23.00
					1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			764,709	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			-764,709	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			-243,385	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,576,608	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			13,346,214	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140032

Period: 07/01/2015 To 06/30/2016

Worksheet A
Date/Time Prepared: 11/30/2016 1:46 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		6,118,611	6,118,611	-3,785,000	2,333,611	1.00
2.00	00200		-254	-254	4,495,747	4,495,493	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	3,571	24,123,240	24,126,811	83,848	24,210,659	4.00
5.00	00500	5,135,559	19,367,118	24,502,677	213,135	24,715,812	5.00
6.00	00600	0	79,141	79,141	0	79,141	6.00
7.00	00700	827,649	1,515,306	2,342,955	0	2,342,955	7.00
8.00	00800	70,568	481,748	552,316	0	552,316	8.00
9.00	00900	646,564	231,965	878,529	0	878,529	9.00
10.00	01000	759,690	415,837	1,175,527	-747,621	427,906	10.00
11.00	01100	57,624	901	58,525	747,621	806,146	11.00
13.00	01300	935,309	31,158	966,467	0	966,467	13.00
14.00	01400	16,004	1,234,660	1,250,664	-1,205,641	45,023	14.00
15.00	01500	1,224,056	4,062,962	5,287,018	-3,690,028	1,596,990	15.00
16.00	01600	2,360,325	1,145,000	3,505,325	0	3,505,325	16.00
17.00	01700	48	4,527	4,575	0	4,575	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,162,070	1,268,046	7,430,116	-1,369,282	6,060,834	30.00
31.00	03100	1,235,106	108,095	1,343,201	-32,966	1,310,235	31.00
43.00	04300	0	20,921	20,921	306,369	327,290	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,663,366	11,668,280	15,331,646	-10,180,091	5,151,555	50.00
52.00	05200	0	107,516	107,516	792,731	900,247	52.00
53.00	05300	1,592,632	2,184,165	3,776,797	-81,914	3,694,883	53.00
54.00	05400	1,659,296	778,012	2,437,308	-147,502	2,289,806	54.00
54.01	03630	176,854	54,022	230,876	-40,088	190,788	54.01
54.02	03450	162,541	324,190	486,731	-11,736	474,995	54.02
54.06	05404	0	99,630	99,630	0	99,630	54.06
57.00	05700	234,380	395,167	629,547	-14,706	614,841	57.00
58.00	05800	183,528	289,412	472,940	-3,361	469,579	58.00
59.00	05900	337,935	680,588	1,018,523	-579,455	439,068	59.00
60.00	06000	1,331,120	2,001,024	3,332,144	-794,423	2,537,721	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	664,725	156,177	820,902	-55,680	765,222	65.00
66.00	06600	1,150,759	326,343	1,477,102	-8,706	1,468,396	66.00
67.00	06700	287,459	34,988	322,447	-24,064	298,383	67.00
69.00	06900	499,615	330,890	830,505	-20,667	809,838	69.00
70.00	07000	99,638	43,165	142,803	-15,254	127,549	70.00
71.00	07100	0	0	0	13,434,477	13,434,477	71.00
73.00	07300	0	0	0	3,914,128	3,914,128	73.00
74.00	07400	0	38,928	38,928	-180	38,748	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	228,132	141,250	369,382	-24,710	344,672	76.01
76.03	03950	314,385	949,175	1,263,560	-85,464	1,178,096	76.03
76.97	07697	72,743	2,696	75,439	-1,874	73,565	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	59,611	198,058	257,669	-2,386	255,283	90.00
91.00	09100	1,918,060	2,229,990	4,148,050	-75,516	4,072,534	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	4,940,102	1,648,023	6,588,125	-247,852	6,340,273	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		581,129	581,129	-581,129	0	113.00
116.00	11600	1,047,672	642,854	1,690,526	-159,845	1,530,681	116.00
118.00		40,058,696	86,114,654	126,173,350	915	126,174,265	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	43,849	43,849	0	43,849	190.00
194.00	07950	72,367	3,308,568	3,380,935	-915	3,380,020	194.00
194.02	07952	0	0	0	0	0	194.02
200.00		40,131,063	89,467,071	129,598,134	0	129,598,134	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A
Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-191,172	2,142,439	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-391,439	4,104,054	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-11,585,641	12,625,018	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,648,254	23,067,558	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	79,141	6.00
7.00	00700	OPERATION OF PLANT	0	2,342,955	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	552,316	8.00
9.00	00900	HOUSEKEEPING	0	878,529	9.00
10.00	01000	DIETARY	0	427,906	10.00
11.00	01100	CAFETERIA	-61	806,085	11.00
13.00	01300	NURSING ADMINISTRATION	-2,007	964,460	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,023	14.00
15.00	01500	PHARMACY	0	1,596,990	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-81,479	3,423,846	16.00
17.00	01700	SOCIAL SERVICE	0	4,575	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-3,768	6,057,066	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,310,235	31.00
43.00	04300	NURSERY	0	327,290	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-181,515	4,970,040	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	900,247	52.00
53.00	05300	ANESTHESIOLOGY	-3,258,067	436,816	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,722	2,284,084	54.00
54.01	03630	ULTRASOUND	0	190,788	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	0	474,995	54.02
54.06	05404	PET SCAN	0	99,630	54.06
57.00	05700	CT SCAN	0	614,841	57.00
58.00	05800	MRI	0	469,579	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	439,068	59.00
60.00	06000	LABORATORY	-25,825	2,511,896	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	765,222	65.00
66.00	06600	PHYSICAL THERAPY	-3,986	1,464,410	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	298,383	67.00
69.00	06900	ELECTROCARDIOLOGY	-179,301	630,537	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-25,025	102,524	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	13,434,477	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,879	3,907,249	73.00
74.00	07400	RENAL DIALYSIS	0	38,748	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03650	VASCULAR LAB	0	344,672	76.01
76.03	03950	WOUND CARE	-342,794	835,302	76.03
76.97	07697	CARDIAC REHABILITATION	0	73,565	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	255,283	90.00
91.00	09100	EMERGENCY	-1,633,393	2,439,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-713	6,339,560	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	1,530,681	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-19,567,041	106,607,224	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	43,849	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	3,380,020	194.00
194.02	07952	MEALS ON WHEELS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-19,567,041	110,031,093	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - PERSONNEL COSTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	86,002	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	2,154	0	2.00	
	0		2,154	86,002		
B - CAFETERIA COSTS						
1.00	CAFETERIA	11.00	452,495	295,126	1.00	
	0		452,495	295,126		
C - PHARMACY DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,914,128	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
	0		0	3,914,128		
D - CENTRAL SUPPLY						
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	13,434,477	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	426,601	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
	0		0	13,861,078		
E - BUSINESS PROPERTY INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	129,618	1.00	
	0		0	129,618		
F - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	191,172	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	389,957	2.00	
	0		0	581,129		
G - DEPRECIATION EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,105,790	1.00	
TOTALS						
			0	4,105,790		

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6
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Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
H - LABOR & DELIVERY					
1.00	NURSERY	43.00	322,410	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	867,605	0	2.00
	TOTALS		1,190,015	0	
500.00	Grand Total: Increases		1,644,664	22,972,871	500.00

RECLASSIFICATIONS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6
Date/Time Prepared:
11/30/2016 1:46 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - PERSONNEL COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	86,002	0		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,154	0	0		2.00
			2,154	86,002			
B - CAFETERIA COSTS							
1.00	DIETARY	10.00	452,495	295,126	0		1.00
			452,495	295,126			
C - PHARMACY DRUGS							
1.00	PHARMACY	15.00	0	3,683,675	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	15,779	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	2,285	0		3.00
4.00	OPERATING ROOM	50.00	0	25,296	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	35,253	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,583	0		6.00
7.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.02	0	10,118	0		7.00
8.00	MRI	58.00	0	352	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	677	0		9.00
10.00	LABORATORY	60.00	0	48	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	30	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	19	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	1	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	882	0		14.00
15.00	VASCULAR LAB	76.01	0	351	0		15.00
16.00	WOUND CARE	76.03	0	5,809	0		16.00
17.00	CLINIC	90.00	0	19	0		17.00
18.00	EMERGENCY	91.00	0	5,433	0		18.00
19.00	HOME HEALTH AGENCY	101.00	0	1,279	0		19.00
20.00	HOSPICE	116.00	0	120,239	0		20.00
			0	3,914,128			
D - CENTRAL SUPPLY							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,205,641	0		1.00
2.00	PHARMACY	15.00	0	6,353	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	163,488	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	30,681	0		4.00
5.00	NURSERY	43.00	0	16,041	0		5.00
6.00	OPERATING ROOM	50.00	0	10,154,795	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	74,874	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	46,661	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	140,919	0		9.00
10.00	ULTRASOUND	54.01	0	40,088	0		10.00
11.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.02	0	1,618	0		11.00
12.00	CT SCAN	57.00	0	14,706	0		12.00
13.00	MRI	58.00	0	3,009	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	578,778	0		14.00
15.00	LABORATORY	60.00	0	794,375	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	55,650	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	8,687	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	24,063	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	19,785	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	15,254	0		20.00
21.00	RENAL DIALYSIS	74.00	0	180	0		21.00
22.00	VASCULAR LAB	76.01	0	24,359	0		22.00
23.00	WOUND CARE	76.03	0	79,655	0		23.00
24.00	CARDIAC REHABILITATION	76.97	0	1,874	0		24.00
25.00	CLINIC	90.00	0	2,367	0		25.00
26.00	EMERGENCY	91.00	0	70,083	0		26.00
27.00	HOME HEALTH AGENCY	101.00	0	246,573	0		27.00
28.00	HOSPICE	116.00	0	39,606	0		28.00
29.00	PHILANTHROPY DEVELOPMENT	194.00	0	915	0		29.00
			0	13,861,078			
E - BUSINESS PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	129,618	9		1.00
			0	129,618			
F - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	581,129	9		1.00
2.00		0.00	0	0	9		2.00
			0	581,129			
G - DEPRECIATION EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,105,790	9		1.00
	TOTALS		0	4,105,790			
H - LABOR & DELIVERY							
1.00	ADULTS & PEDIATRICS	30.00	1,190,015	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,190,015	0			

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6
Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
500.00	Grand Total: Decreases		1,644,664	22,972,871			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part I
Date/Time Prepared:
11/30/2016 1:46 pm

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,875,531	0	0	0	-175,957	1.00
2.00	Land Improvements	3,431,092	0	0	0	0	2.00
3.00	Buildings and Fixtures	68,782,219	9,517,890	0	9,517,890	-7,028,056	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	15,071,210	3,750	0	3,750	0	5.00
6.00	Movable Equipment	72,876,230	2,018,001	0	2,018,001	-269,889	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	163,036,282	11,539,641	0	11,539,641	-7,473,902	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	163,036,282	11,539,641	0	11,539,641	-7,473,902	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,051,488	0				1.00
2.00	Land Improvements	3,431,092	2,090,408				2.00
3.00	Buildings and Fixtures	85,328,165	28,851,341				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	15,074,960	13,983,196				5.00
6.00	Movable Equipment	75,164,120	62,986,793				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	182,049,825	107,911,738				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	182,049,825	107,911,738				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part II
Date/Time Prepared:
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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	6,118,611	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-254	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,118,357	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	6,118,611				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	-254				2.00
3.00	Total (sum of lines 1-2)	0	6,118,357				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,333,611	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,494,012	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,827,623	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-191,172	0	0	0	2,142,439	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-389,958	0	0	0	4,104,054	2.00
3.00	Total (sum of lines 1-2)	-581,130	0	0	0	6,246,493	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-191,172	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-389,958	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-1,481	CAP REL COSTS-MVBLE EQUIP	2.00	9	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	-3,695,531			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,588,169			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 employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		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 OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 *** Cost Center Deleted ***	68.00		31.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 MISC INCOME	B	-540,295	ADMINISTRATIVE & GENERAL		5.00	0	33.00
33.01 MISC INCOME	B	-61	CAFETERIA		11.00	0	33.01
33.02 MISC INCOME	B	-2,007	NURSING ADMINISTRATION		13.00	0	33.02
33.03 MISC INCOME	B	-81,479	MEDICAL RECORDS & LIBRARY		16.00	0	33.03
33.04 MISC INCOME	B	-3,768	ADULTS & PEDIATRICS		30.00	0	33.04
33.05 MISC INCOME	B	-36	OPERATING ROOM		50.00	0	33.05
33.06 MISC INCOME	B	-1,718,862	ANESTHESIOLOGY		53.00	0	33.06
33.07 MISC INCOME	B	-70	RADIOLOGY-DIAGNOSTIC		54.00	0	33.07
33.08 MISC INCOME	B	-825	LABORATORY		60.00	0	33.08
33.09 MISC INCOME	B	-3,986	PHYSICAL THERAPY		66.00	0	33.09
33.10 MISC INCOME	B	-6,879	DRUGS CHARGED TO PATIENTS		73.00	0	33.10
33.11 MISC INCOME	B	-75	EMERGENCY		91.00	0	33.11
33.12 MISC INCOME	B	-713	HOME HEALTH AGENCY		101.00	0	33.12
33.13 TELEPHONE EMPLOYEE BENEFITS	A	-3,983	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.13
33.14 TELEPHONE A&G SALARIES	A	-11,460	ADMINISTRATIVE & GENERAL		5.00	0	33.14
33.15 TELEPHONE A&G OTHER EXPENSE	A	-639	ADMINISTRATIVE & GENERAL		5.00	0	33.15
33.16 TELEVISION EMPLOYEE BENEFITS	A	-757	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.16
33.17 TELEVISION A&G SALARIES	A	-2,178	ADMINISTRATIVE & GENERAL		5.00	0	33.17
33.18 TELEVISION A&G OTHER EXPENSE	A	-486	ADMINISTRATIVE & GENERAL		5.00	0	33.18
33.19 TELEVISION A&G OTHER CABLE EXPENSE	A	-16,350	ADMINISTRATIVE & GENERAL		5.00	0	33.19
33.20 PHYSICIAN RECRUITMENT	A	-10,464	ADMINISTRATIVE & GENERAL		5.00	0	33.20
33.21 MEDICAID TAX ASSESSMENT	A	-3,113,519	ADMINISTRATIVE & GENERAL		5.00	0	33.21
33.22 SELF-INS TO HOSP/EMP CLAIMS	A	-2,719,836	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.22
33.23 LOBBYING EXPENSES	A	-30,442	ADMINISTRATIVE & GENERAL		5.00	0	33.23
33.24 COUNTRY CLUB FEES	A	-2,895	ADMINISTRATIVE & GENERAL		5.00	0	33.24
33.25 ALCOHOL BEVERAGE COST	A	-549	ADMINISTRATIVE & GENERAL		5.00	0	33.25
33.26 DEFINED PENSION ADJUSTMENT	A	-8,368,211	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.26
33.27 CRNA EXPENSE	A	-236,243	ANESTHESIOLOGY		53.00	0	33.27
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,567,041					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: 140032
 Period: From 07/01/2015 To 06/30/2016
 Worksheet A-8-1
 Date/Time Prepared: 11/30/2016 1:46 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HEALTH & DENTAL PREMIUM	8,289,826	8,271,200 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC	7,197,131	5,134,734 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CONTRACTED SERVICES - SSC	2,093,811	2,586,665 3.00
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.			17,580,768	15,992,599 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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	G	HSHS	0.00	HSHS	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-1

Date/Time Prepared:
11/30/2016 1:46 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	18,626	0		1.00
2.00	2,062,397	0		2.00
3.00	-492,854	0		3.00
4.00	0	0		4.00
5.00	1,588,169			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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	CORPORATE OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-2

Date/Time Prepared:
11/30/2016 1:46 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,633,318	1,633,318	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	1,302,962	1,302,962	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	179,301	179,301	0	0	0	3.00
4.00	60.00	LABORATORY	25,000	25,000	0	0	0	4.00
5.00	76.03	WOUND CARE	342,794	342,794	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	5,652	5,652	0	0	0	6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	25,025	25,025	0	0	0	7.00
8.00	50.00	OPERATING ROOM	181,479	181,479	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			3,695,531	3,695,531	0	0	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	76.03	WOUND CARE	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	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	91.00	EMERGENCY	0	0	0	1,633,318		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	1,302,962		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	179,301		3.00
4.00	60.00	LABORATORY	0	0	0	25,000		4.00
5.00	76.03	WOUND CARE	0	0	0	342,794		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,652		6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	25,025		7.00
8.00	50.00	OPERATING ROOM	0	0	0	181,479		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	3,695,531		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140032

Period: 07/01/2015
To: 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,142,439	2,142,439			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,104,054		4,104,054		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,625,018	8,228	0	12,633,246	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	23,067,558	604,329	648,861	1,617,409	25,938,157
6.00 00600	MAINTENANCE & REPAIRS	79,141	27,410	33,175	0	139,726
7.00 00700	OPERATION OF PLANT	2,342,955	344,791	1,358,560	260,553	4,306,859
8.00 00800	LAUNDRY & LINEN SERVICE	552,316	20,367	1,757	22,216	596,656
9.00 00900	HOUSEKEEPING	878,529	24,684	993	203,545	1,107,751
10.00 01000	DIETARY	427,906	28,975	16,735	99,344	572,960
11.00 01100	CAFETERIA	806,085	10,387	737	157,955	975,164
13.00 01300	NURSING ADMINISTRATION	964,460	16,121	2,395	294,446	1,277,422
14.00 01400	CENTRAL SERVICES & SUPPLY	45,023	39,020	0	5,038	89,081
15.00 01500	PHARMACY	1,596,990	21,772	25,176	385,346	2,029,284
16.00 01600	MEDICAL RECORDS & LIBRARY	3,423,846	33,099	47,075	743,056	4,247,076
17.00 01700	SOCIAL SERVICE	4,575	0	0	15	4,590
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,057,066	276,602	169,995	1,939,880	8,443,543
31.00 03100	INTENSIVE CARE UNIT	1,310,235	27,977	90,302	388,825	1,817,339
43.00 04300	NURSERY	327,290	5,135	2,378	0	334,803
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,970,040	211,474	650,339	1,153,268	6,985,121
52.00 05200	DELIVERY ROOM & LABOR ROOM	900,247	30,142	54,766	0	985,155
53.00 05300	ANESTHESIOLOGY	436,816	1,263	66,615	501,378	1,006,072
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,284,084	89,819	250,257	522,365	3,146,525
54.01 03630	ULTRASOUND	190,788	3,531	58,903	55,676	308,898
54.02 03450	NUCLEAR MEDICINE-DIAGNOSTIC	474,995	15,664	10,935	51,170	552,764
54.06 05404	PET SCAN	99,630	1,289	0	0	100,919
57.00 05700	CT SCAN	614,841	9,027	14,944	73,785	712,597
58.00 05800	MRI	469,579	31,205	34,261	57,777	592,822
59.00 05900	CARDIAC CATHETERIZATION	439,068	11,933	24,923	106,386	582,310
60.00 06000	LABORATORY	2,511,896	50,638	57,629	419,051	3,039,214
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	765,222	9,368	26,570	209,263	1,010,423
66.00 06600	PHYSICAL THERAPY	1,464,410	0	11,880	362,272	1,838,562
67.00 06700	OCCUPATIONAL THERAPY	298,383	0	0	90,495	388,878
69.00 06900	ELECTROCARDIOLOGY	630,537	26,089	79,734	157,284	893,644
70.00 07000	ELECTROENCEPHALOGRAPHY	102,524	4,401	5,133	31,367	143,425
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	13,434,477	0	0	0	13,434,477
73.00 07300	DRUGS CHARGED TO PATIENTS	3,907,249	0	0	0	3,907,249
74.00 07400	RENAL DIALYSIS	38,748	2,880	0	0	41,628
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03650	VASCULAR LAB	344,672	2,455	70,051	71,818	488,996
76.03 03950	WOUND CARE	835,302	28,718	5,405	98,972	968,397
76.97 07697	CARDIAC REHABILITATION	73,565	4,253	1,619	22,900	102,337
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	255,283	8,698	0	18,766	282,747
91.00 09100	EMERGENCY	2,439,141	59,529	87,116	603,826	3,189,612
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	6,339,560	22,429	107,084	1,555,198	8,024,271
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	1,530,681	5,876	0	329,819	1,866,376
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	106,607,224	2,119,578	4,016,303	12,610,464	106,473,830
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	43,849	3,563	2,584	0	49,996
194.00 07950	PHILANTHROPY DEVELOPMENT	3,380,020	19,298	85,167	22,782	3,507,267
194.02 07952	MEALS ON WHEELS	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	110,031,093	2,142,439	4,104,054	12,633,246	110,031,093

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part I Date/Time Prepared: 11/30/2016 1:46 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	25,938,157				5.00	
6.00	00600	MAINTENANCE & REPAIRS	43,098	182,824			6.00	
7.00	00700	OPERATION OF PLANT	1,328,433	70,059	5,705,351		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	184,036	1,676	100,375	882,743	8.00	
9.00	00900	HOUSEKEEPING	341,681	1,609	121,650	0	1,572,691	9.00
10.00	01000	DIETARY	176,727	5,397	142,798	5,886	40,951	10.00
11.00	01100	CAFETERIA	300,785	34	51,188	0	14,678	11.00
13.00	01300	NURSING ADMINISTRATION	394,016	4,442	79,449	0	22,783	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,477	0	192,303	0	55,144	14.00
15.00	01500	PHARMACY	625,925	1,978	107,297	0	30,767	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,309,994	1,341	163,121	0	46,772	16.00
17.00	01700	SOCIAL SERVICE	1,416	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,604,377	22,995	1,363,170	296,345	390,895	30.00
31.00	03100	INTENSIVE CARE UNIT	560,551	5,028	137,876	37,018	39,537	31.00
43.00	04300	NURSERY	103,269	1,525	25,308	0	7,257	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,154,533	22,643	1,042,201	225,208	298,857	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	303,867	5,632	148,546	56,063	42,596	52.00
53.00	05300	ANESTHESIOLOGY	310,319	1,106	6,224	0	1,785	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	970,533	7,911	442,652	29,729	125,112	54.00
54.01	03630	ULTRASOUND	95,278	67	17,401	4,498	4,990	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	170,498	419	77,194	3,357	22,135	54.02
54.06	05404	PET SCAN	31,128	0	6,351	0	1,821	54.06
57.00	05700	CT SCAN	219,798	34	44,487	11,278	12,757	57.00
58.00	05800	MRI	182,854	151	153,785	18,959	44,099	58.00
59.00	05900	CARDIAC CATHETERIZATION	179,611	1,458	58,809	214	16,864	59.00
60.00	06000	LABORATORY	937,433	3,402	249,555	0	73,383	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	311,661	6,252	46,170	14,597	17,720	65.00
66.00	06600	PHYSICAL THERAPY	567,097	3,721	0	9,435	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	119,948	50	0	2,716	0	67.00
69.00	06900	ELECTROCARDIOLOGY	275,641	1,877	128,572	4,863	36,867	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,239	0	21,688	86	6,220	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	4,143,839	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,205,175	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	12,840	0	14,194	0	4,070	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	150,829	168	12,098	1,263	3,469	76.01
76.03	03950	WOUND CARE	298,698	704	141,528	9,426	40,584	76.03
76.97	07697	CARDIAC REHABILITATION	31,565	888	20,958	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	87,212	1,073	42,868	1,087	12,292	90.00
91.00	09100	EMERGENCY	983,823	7,626	293,376	0	84,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,475,054	1,022	110,536	145,405	31,697	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	575,676	0	28,960	3,642	8,304	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,840,934	182,288	5,592,688	881,075	1,538,536	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	15,421	0	17,560	0	5,035	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	1,081,802	536	95,103	1,668	29,120	194.00
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	25,938,157	182,824	5,705,351	882,743	1,572,691	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	944,719					10.00
11.00	01100	0	1,341,849				11.00
13.00	01300	0	29,655	1,807,767			13.00
14.00	01400	0	0	0	364,005		14.00
15.00	01500	0	0	0	5,372	2,800,623	15.00
16.00	01600	0	96,693	0	1	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	846,773	260,743	613,123	4,033	214,636	30.00
31.00	03100	97,946	50,998	101,768	750	27,872	31.00
43.00	04300	0	13,722	0	392	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	167,994	322,416	248,349	275,955	50.00
52.00	05200	0	36,956	0	1,831	0	52.00
53.00	05300	0	2,878	0	1,141	430,016	53.00
54.00	05400	0	80,493	0	3,611	80,299	54.00
54.01	03630	0	6,635	0	981	0	54.01
54.02	03450	0	6,635	0	5,647	123,419	54.02
54.06	05404	0	0	0	0	0	54.06
57.00	05700	0	11,058	0	2,185	0	57.00
58.00	05800	0	8,873	0	1,157	4,294	58.00
59.00	05900	0	14,575	0	14,156	8,258	59.00
60.00	06000	0	78,308	0	29,730	586	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	37,915	0	2,200	366	65.00
66.00	06600	0	52,517	0	192	232	66.00
67.00	06700	0	10,525	0	589	12	67.00
69.00	06900	0	20,996	0	484	10,759	69.00
70.00	07000	0	4,423	0	373	0	70.00
71.00	07100	0	1,092	0	29,489	0	71.00
73.00	07300	0	37,569	0	0	0	73.00
74.00	07400	0	0	0	4	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	0	8,580	0	596	4,281	76.01
76.03	03950	0	16,466	0	1,948	70,858	76.03
76.97	07697	0	2,984	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	2,904	0	0	0	90.00
91.00	09100	0	110,522	224,228	1,772	66,503	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	120,913	453,244	7,000	1,482,277	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	45,536	92,988	0	0	116.00
118.00		944,719	1,339,158	1,807,767	363,983	2,800,623	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	2,691	0	22	0	194.00
194.02	07952	0	0	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		944,719	1,341,849	1,807,767	364,005	2,800,623	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,864,998				16.00
17.00	01700	SOCIAL SERVICE	0	6,006			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,256,798	5,383	20,322,814	0	30.00
31.00	03100	INTENSIVE CARE UNIT	608,200	623	3,485,506	0	31.00
43.00	04300	NURSERY	0	0	486,276	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	11,743,277	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	1,580,646	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,759,541	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	4,886,865	0	54.00
54.01	03630	ULTRASOUND	0	0	438,748	0	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	962,068	0	54.02
54.06	05404	PET SCAN	0	0	140,219	0	54.06
57.00	05700	CT SCAN	0	0	1,014,194	0	57.00
58.00	05800	MRI	0	0	1,006,994	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	876,255	0	59.00
60.00	06000	LABORATORY	0	0	4,411,611	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	1,447,304	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,471,756	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	522,718	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,373,703	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	220,454	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	17,608,897	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,149,993	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	72,736	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	0	670,280	0	76.01
76.03	03950	WOUND CARE	0	0	1,548,609	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	158,732	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	430,183	0	90.00
91.00	09100	EMERGENCY	0	0	4,961,592	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	12,851,419	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	2,621,482	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,864,998	6,006	105,224,872	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	88,012	0	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	0	0	4,718,209	0	194.00
194.02	07952	MEALS ON WHEELS	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,864,998	6,006	110,031,093	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140032

Period: From 07/01/2015 To 06/30/2016

Worksheet B Part II Date/Time Prepared: 11/30/2016 1:46 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,228	0	8,228	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,138,990	604,329	648,861	3,392,180	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	27,410	33,175	60,585	6.00
7.00 00700	OPERATION OF PLANT	17,225	344,791	1,358,560	1,720,576	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	20,367	1,757	22,124	8.00
9.00 00900	HOUSEKEEPING	0	24,684	993	25,677	9.00
10.00 01000	DIETARY	640	28,975	16,735	46,350	10.00
11.00 01100	CAFETERIA	0	10,387	737	11,124	11.00
13.00 01300	NURSING ADMINISTRATION	0	16,121	2,395	18,516	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	39,020	0	39,020	14.00
15.00 01500	PHARMACY	290,845	21,772	25,176	337,793	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,099	47,075	80,174	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	11,254	276,602	169,995	457,851	30.00
31.00 03100	INTENSIVE CARE UNIT	0	27,977	90,302	118,279	31.00
43.00 04300	NURSERY	0	5,135	2,378	7,513	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	290,098	211,474	650,339	1,151,911	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	30,142	54,766	84,908	52.00
53.00 05300	ANESTHESIOLOGY	0	1,263	66,615	67,878	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	146,156	89,819	250,257	486,232	54.00
54.01 03630	ULTRASOUND	1,828	3,531	58,903	64,262	54.01
54.02 03450	NUCLEAR MEDICINE-DIAGNOSTIC	0	15,664	10,935	26,599	54.02
54.06 05404	PET SCAN	0	1,289	0	1,289	54.06
57.00 05700	CT SCAN	15,500	9,027	14,944	39,471	57.00
58.00 05800	MRI	0	31,205	34,261	65,466	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	11,933	24,923	36,856	59.00
60.00 06000	LABORATORY	98,505	50,638	57,629	206,772	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	61,376	9,368	26,570	97,314	65.00
66.00 06600	PHYSICAL THERAPY	59,647	0	11,880	71,527	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	26,089	79,734	105,823	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,667	4,401	5,133	11,201	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	2,880	0	2,880	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01 03650	VASCULAR LAB	0	2,455	70,051	72,506	76.01
76.03 03950	WOUND CARE	0	28,718	5,405	34,123	76.03
76.97 07697	CARDIAC REHABILITATION	0	4,253	1,619	5,872	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	8,698	0	8,698	90.00
91.00 09100	EMERGENCY	0	59,529	87,116	146,645	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	66,037	22,429	107,084	195,550	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00 11600	HOSPICE	0	5,876	0	5,876	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,199,768	2,119,578	4,016,303	9,335,649	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	0	3,563	2,584	6,147	190.00
194.00 07950	PHILANTHROPY DEVELOPMENT	0	19,298	85,167	104,465	194.00
194.02 07952	MEALS ON WHEELS	0	0	0	0	194.02
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,199,768	2,142,439	4,104,054	9,446,261	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/30/2016 1:46 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,393,233					5.00
6.00	00600	MAINTENANCE & REPAIRS	5,638	66,223				6.00
7.00	00700	OPERATION OF PLANT	173,786	25,377	1,919,909			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,076	607	33,777	80,598		8.00
9.00	00900	HOUSEKEEPING	44,699	583	40,936	0	112,028	9.00
10.00	01000	DIETARY	23,120	1,955	48,053	537	2,917	10.00
11.00	01100	CAFETERIA	39,349	12	17,225	0	1,046	11.00
13.00	01300	NURSING ADMINISTRATION	51,545	1,609	26,735	0	1,623	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,595	0	64,712	0	3,928	14.00
15.00	01500	PHARMACY	81,884	716	36,107	0	2,192	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	171,374	486	54,892	0	3,332	16.00
17.00	01700	SOCIAL SERVICE	185	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	340,705	8,329	458,723	27,057	27,844	30.00
31.00	03100	INTENSIVE CARE UNIT	73,331	1,821	46,397	3,380	2,816	31.00
43.00	04300	NURSERY	13,510	552	8,516	0	517	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	281,857	8,202	350,711	20,562	21,289	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,752	2,040	49,987	5,119	3,034	52.00
53.00	05300	ANESTHESIOLOGY	40,596	401	2,094	0	127	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	126,965	2,866	148,957	2,714	8,912	54.00
54.01	03630	ULTRASOUND	12,464	24	5,856	411	355	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	22,305	152	25,977	307	1,577	54.02
54.06	05404	PET SCAN	4,072	0	2,137	0	130	54.06
57.00	05700	CT SCAN	28,754	12	14,970	1,030	909	57.00
58.00	05800	MRI	23,921	55	51,750	1,731	3,141	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,497	528	19,790	20	1,201	59.00
60.00	06000	LABORATORY	122,635	1,232	83,978	0	5,227	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	40,772	2,265	15,537	1,333	1,262	65.00
66.00	06600	PHYSICAL THERAPY	74,188	1,348	0	861	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,692	18	0	248	0	67.00
69.00	06900	ELECTROCARDIOLOGY	36,059	680	43,266	444	2,626	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,787	0	7,298	8	443	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	542,094	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,661	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,680	0	4,776	0	290	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	19,731	61	4,071	115	247	76.01
76.03	03950	WOUND CARE	39,076	255	47,626	861	2,891	76.03
76.97	07697	CARDIAC REHABILITATION	4,129	322	7,052	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,409	389	14,426	99	876	90.00
91.00	09100	EMERGENCY	128,704	2,762	98,724	0	5,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	323,787	370	37,196	13,276	2,258	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	75,310	0	9,745	333	592	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,249,694	66,029	1,881,997	80,446	109,595	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	2,017	0	5,909	0	359	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	141,522	194	32,003	152	2,074	194.00
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,393,233	66,223	1,919,909	80,598	112,028	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/30/2016 1:46 pm
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	122,997					10.00	
11.00	01100	0	68,859				11.00	
13.00	01300	0	1,522	101,742			13.00	
14.00	01400	0	0	0	111,258		14.00	
15.00	01500	0	0	0	1,642	460,585	15.00	
16.00	01600	0	4,962	0	0	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	110,245	13,381	34,506	1,233	35,299	30.00	
31.00	03100	12,752	2,617	5,728	229	4,584	31.00	
43.00	04300	0	704	0	120	0	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	8,621	18,146	75,906	45,383	50.00	
52.00	05200	0	1,896	0	560	0	52.00	
53.00	05300	0	148	0	349	70,720	53.00	
54.00	05400	0	4,131	0	1,104	13,206	54.00	
54.01	03630	0	340	0	300	0	54.01	
54.02	03450	0	340	0	1,726	20,297	54.02	
54.06	05404	0	0	0	0	0	54.06	
57.00	05700	0	567	0	668	0	57.00	
58.00	05800	0	455	0	354	706	58.00	
59.00	05900	0	748	0	4,327	1,358	59.00	
60.00	06000	0	4,019	0	9,087	96	60.00	
62.30	06250	0	0	0	0	0	62.30	
65.00	06500	0	1,946	0	672	60	65.00	
66.00	06600	0	2,695	0	59	38	66.00	
67.00	06700	0	540	0	180	2	67.00	
69.00	06900	0	1,077	0	148	1,769	69.00	
70.00	07000	0	227	0	114	0	70.00	
71.00	07100	0	56	0	9,013	0	71.00	
73.00	07300	0	1,928	0	0	0	73.00	
74.00	07400	0	0	0	1	0	74.00	
76.00	03050	0	0	0	0	0	76.00	
76.01	03650	0	440	0	182	704	76.01	
76.03	03950	0	845	0	596	11,653	76.03	
76.97	07697	0	153	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	149	0	0	0	90.00	
91.00	09100	0	5,672	12,620	542	10,937	91.00	
92.00	09200	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	0	6,205	25,509	2,139	243,773	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
116.00	11600	0	2,337	5,233	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		122,997	68,721	101,742	111,251	460,585	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
194.00	07950	0	138	0	7	0	194.00	
194.02	07952	0	0	0	0	0	194.02	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		122,997	68,859	101,742	111,258	460,585	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/30/2016 1:46 pm	
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600	315,704					16.00
17.00	01700	0	185				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	282,965	166	1,799,570	0	1,799,570	30.00
31.00	03100	32,739	19	304,945	0	304,945	31.00
43.00	04300	0	0	31,432	0	31,432	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	1,983,339	0	1,983,339	50.00
52.00	05200	0	0	187,296	0	187,296	52.00
53.00	05300	0	0	182,639	0	182,639	53.00
54.00	05400	0	0	795,427	0	795,427	54.00
54.01	03630	0	0	84,048	0	84,048	54.01
54.02	03450	0	0	99,313	0	99,313	54.02
54.06	05404	0	0	7,628	0	7,628	54.06
57.00	05700	0	0	86,429	0	86,429	57.00
58.00	05800	0	0	147,617	0	147,617	58.00
59.00	05900	0	0	88,394	0	88,394	59.00
60.00	06000	0	0	433,319	0	433,319	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	161,297	0	161,297	65.00
66.00	06600	0	0	150,952	0	150,952	66.00
67.00	06700	0	0	16,739	0	16,739	67.00
69.00	06900	0	0	191,994	0	191,994	69.00
70.00	07000	0	0	25,098	0	25,098	70.00
71.00	07100	0	0	551,163	0	551,163	71.00
73.00	07300	0	0	159,589	0	159,589	73.00
74.00	07400	0	0	9,627	0	9,627	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	0	0	98,104	0	98,104	76.01
76.03	03950	0	0	137,990	0	137,990	76.03
76.97	07697	0	0	17,543	0	17,543	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	36,058	0	36,058	90.00
91.00	09100	0	0	412,992	0	412,992	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	851,076	0	851,076	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	99,641	0	99,641	116.00
118.00		315,704	185	9,151,259	0	9,151,259	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	14,432	0	14,432	190.00
194.00	07950	0	0	280,570	0	280,570	194.00
194.02	07952	0	0	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		315,704	185	9,446,261	0	9,446,261	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	332,509				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		6,118,610			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,277	0	40,129,646		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	93,793	967,368	5,137,713	-25,938,157	84,092,936
6.00 00600	MAINTENANCE & REPAIRS	4,254	49,460	0	0	139,726
7.00 00700	OPERATION OF PLANT	53,512	2,025,433	827,649	0	4,306,859
8.00 00800	LAUNDRY & LINEN SERVICE	3,161	2,620	70,568	0	596,656
9.00 00900	HOUSEKEEPING	3,831	1,481	646,564	0	1,107,751
10.00 01000	DIETARY	4,497	24,949	315,568	0	572,960
11.00 01100	CAFETERIA	1,612	1,099	501,746	0	975,164
13.00 01300	NURSING ADMINISTRATION	2,502	3,570	935,309	0	1,277,422
14.00 01400	CENTRAL SERVICES & SUPPLY	6,056	0	16,004	0	89,081
15.00 01500	PHARMACY	3,379	37,534	1,224,056	0	2,029,284
16.00 01600	MEDICAL RECORDS & LIBRARY	5,137	70,183	2,360,325	0	4,247,076
17.00 01700	SOCIAL SERVICE	0	0	48	0	4,590
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	42,929	253,441	6,162,070	0	8,443,543
31.00 03100	INTENSIVE CARE UNIT	4,342	134,628	1,235,106	0	1,817,339
43.00 04300	NURSERY	797	3,546	0	0	334,803
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	32,821	969,571	3,663,366	0	6,985,121
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,678	81,649	0	0	985,155
53.00 05300	ANESTHESIOLOGY	196	99,315	1,592,632	0	1,006,072
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,940	373,101	1,659,296	0	3,146,525
54.01 03630	ULTRASOUND	548	87,817	176,854	0	308,898
54.02 03450	NUCLEAR MEDICINE-DIAGNOSTIC	2,431	16,303	162,541	0	552,764
54.06 05404	PET SCAN	200	0	0	0	100,919
57.00 05700	CT SCAN	1,401	22,279	234,380	0	712,597
58.00 05800	MRI	4,843	51,078	183,528	0	592,822
59.00 05900	CARDIAC CATHETERIZATION	1,852	37,157	337,935	0	582,310
60.00 06000	LABORATORY	7,859	85,918	1,331,120	0	3,039,214
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	1,454	39,612	664,725	0	1,010,423
66.00 06600	PHYSICAL THERAPY	0	17,712	1,150,759	0	1,838,562
67.00 06700	OCCUPATIONAL THERAPY	0	0	287,459	0	388,878
69.00 06900	ELECTROCARDIOLOGY	4,049	118,873	499,615	0	893,644
70.00 07000	ELECTROENCEPHALOGRAPHY	683	7,652	99,638	0	143,425
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	13,434,477
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,907,249
74.00 07400	RENAL DIALYSIS	447	0	0	0	41,628
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03650	VASCULAR LAB	381	104,437	228,132	0	488,996
76.03 03950	WOUND CARE	4,457	8,058	314,385	0	968,397
76.97 07697	CARDIAC REHABILITATION	660	2,414	72,743	0	102,337
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,350	0	59,611	0	282,747
91.00 09100	EMERGENCY	9,239	129,879	1,918,060	0	3,189,612
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	3,481	159,648	4,940,102	0	8,024,271
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
116.00 11600	HOSPICE	912	0	1,047,672	0	1,866,376
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	328,961	5,987,785	40,057,279	-25,938,157	80,535,673
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	553	3,852	0	0	49,996
194.00 07950	PHILANTHROPY DEVELOPMENT	2,995	126,973	72,367	0	3,507,267
194.02 07952	MEALS ON WHEELS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,142,439	4,104,054	12,633,246		25,938,157
203.00	Unit cost multiplier (Wkst. B, Part I)	6.443251	0.670749	0.314811		0.308446
204.00	Cost to be allocated (per Wkst. B, Part II)			8,228		3,393,233
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000205		0.040351

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description		MAINTENANCE & REPAIRS (MAINT. HOURS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	10,908					6.00
7.00	00700	4,180	179,673				7.00
8.00	00800	100	3,161	780,960			8.00
9.00	00900	96	3,831	0	1,530,818		9.00
10.00	01000	322	4,497	5,207	39,861	65,559	10.00
11.00	01100	2	1,612	0	14,287	0	11.00
13.00	01300	265	2,502	0	22,176	0	13.00
14.00	01400	0	6,056	0	53,676	0	14.00
15.00	01500	118	3,379	0	29,948	0	15.00
16.00	01600	80	5,137	0	45,527	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,372	42,929	262,176	380,487	58,762	30.00
31.00	03100	300	4,342	32,750	38,484	6,797	31.00
43.00	04300	91	797	0	7,064	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,351	32,821	199,241	290,900	0	50.00
52.00	05200	336	4,678	49,599	41,462	0	52.00
53.00	05300	66	196	0	1,737	0	53.00
54.00	05400	472	13,940	26,301	121,781	0	54.00
54.01	03630	4	548	3,979	4,857	0	54.01
54.02	03450	25	2,431	2,970	21,546	0	54.02
54.06	05404	0	200	0	1,773	0	54.06
57.00	05700	2	1,401	9,978	12,417	0	57.00
58.00	05800	9	4,843	16,773	42,925	0	58.00
59.00	05900	87	1,852	189	16,415	0	59.00
60.00	06000	203	7,859	0	71,429	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	373	1,454	12,914	17,248	0	65.00
66.00	06600	222	0	8,347	0	0	66.00
67.00	06700	3	0	2,403	0	0	67.00
69.00	06900	112	4,049	4,302	35,885	0	69.00
70.00	07000	0	683	76	6,054	0	70.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	447	0	3,962	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	10	381	1,117	3,377	0	76.01
76.03	03950	42	4,457	8,339	39,503	0	76.03
76.97	07697	53	660	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	64	1,350	962	11,965	0	90.00
91.00	09100	455	9,239	0	81,890	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	61	3,481	128,639	30,853	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	912	3,222	8,083	0	116.00
118.00		10,876	176,125	779,484	1,497,572	65,559	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	553	0	4,901	0	190.00
194.00	07950	32	2,995	1,476	28,345	0	194.00
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		182,824	5,705,351	882,743	1,572,691	944,719	202.00
203.00		16.760543	31.754081	1.130331	1.027353	14.410211	203.00
204.00		66,223	1,919,909	80,598	112,028	122,997	204.00
205.00		6.071049	10.685573	0.103204	0.073182	1.876127	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	50,361					11.00
13.00	01300	1,113	648,779				13.00
14.00	01400	0	0	14,882,025			14.00
15.00	01500	0	0	219,650	229,597		15.00
16.00	01600	3,629	0	43	0	10,000	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,786	220,040	164,869	17,596	8,963	30.00
31.00	03100	1,914	36,523	30,681	2,285	1,037	31.00
43.00	04300	515	0	16,041	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,305	115,710	10,153,414	22,623	0	50.00
52.00	05200	1,387	0	74,874	0	0	52.00
53.00	05300	108	0	46,661	35,253	0	53.00
54.00	05400	3,021	0	147,615	6,583	0	54.00
54.01	03630	249	0	40,088	0	0	54.01
54.02	03450	249	0	230,878	10,118	0	54.02
54.06	05404	0	0	0	0	0	54.06
57.00	05700	415	0	89,338	0	0	57.00
58.00	05800	333	0	47,290	352	0	58.00
59.00	05900	547	0	578,778	677	0	59.00
60.00	06000	2,939	0	1,215,515	48	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	1,423	0	89,942	30	0	65.00
66.00	06600	1,971	0	7,867	19	0	66.00
67.00	06700	395	0	24,063	1	0	67.00
69.00	06900	788	0	19,785	882	0	69.00
70.00	07000	166	0	15,254	0	0	70.00
71.00	07100	41	0	1,205,641	0	0	71.00
73.00	07300	1,410	0	0	0	0	73.00
74.00	07400	0	0	180	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03650	322	0	24,359	351	0	76.01
76.03	03950	618	0	79,655	5,809	0	76.03
76.97	07697	112	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	109	0	0	0	0	90.00
91.00	09100	4,148	80,472	72,451	5,452	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	4,538	162,662	286,178	121,518	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	1,709	33,372	0	0	0	116.00
118.00		50,260	648,779	14,881,110	229,597	10,000	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	101	0	915	0	0	194.00
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		1,341,849	1,807,767	364,005	2,800,623	5,864,998	202.00
203.00		26.644606	2.786414	0.024459	12.197995	586.499800	203.00
204.00		68,859	101,742	111,258	460,585	315,704	204.00
205.00		1.367308	0.156821	0.007476	2.006058	31.570400	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1
Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		10,000	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
		8,963	
		1,037	
		0	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	54.02
54.06	05404	PET SCAN	54.06
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	03650	VASCULAR LAB	76.01
76.03	03950	WOUND CARE	76.03
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		10,000	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	190.00
194.00	07950	PHILANTHROPY DEVELOPMENT	194.00
194.02	07952	MEALS ON WHEELS	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		6,006	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		185	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.018500	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/30/2016 1:46 pm		
			Title XVIII	Hospital	PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	20,322,814		20,322,814	0	20,322,814	30.00
31.00	03100 INTENSIVE CARE UNIT	3,485,506		3,485,506	0	3,485,506	31.00
43.00	04300 NURSERY	486,276		486,276	0	486,276	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,743,277		11,743,277	0	11,743,277	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,580,646		1,580,646	0	1,580,646	52.00
53.00	05300 ANESTHESIOLOGY	1,759,541		1,759,541	0	1,759,541	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,886,865		4,886,865	0	4,886,865	54.00
54.01	03630 ULTRASOUND	438,748		438,748	0	438,748	54.01
54.02	03450 NUCLEAR MEDICINE-DIAGNOSTIC	962,068		962,068	0	962,068	54.02
54.06	05404 PET SCAN	140,219		140,219	0	140,219	54.06
57.00	05700 CT SCAN	1,014,194		1,014,194	0	1,014,194	57.00
58.00	05800 MRI	1,006,994		1,006,994	0	1,006,994	58.00
59.00	05900 CARDIAC CATHETERIZATION	876,255		876,255	0	876,255	59.00
60.00	06000 LABORATORY	4,411,611		4,411,611	0	4,411,611	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,447,304	0	1,447,304	0	1,447,304	65.00
66.00	06600 PHYSICAL THERAPY	2,471,756	0	2,471,756	0	2,471,756	66.00
67.00	06700 OCCUPATIONAL THERAPY	522,718	0	522,718	0	522,718	67.00
69.00	06900 ELECTROCARDIOLOGY	1,373,703		1,373,703	0	1,373,703	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	220,454		220,454	0	220,454	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	17,608,897		17,608,897	0	17,608,897	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,149,993		5,149,993	0	5,149,993	73.00
74.00	07400 RENAL DIALYSIS	72,736		72,736	0	72,736	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03650 VASCULAR LAB	670,280		670,280	0	670,280	76.01
76.03	03950 WOUND CARE	1,548,609		1,548,609	0	1,548,609	76.03
76.97	07697 CARDIAC REHABILITATION	158,732		158,732	0	158,732	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	430,183		430,183	0	430,183	90.00
91.00	09100 EMERGENCY	4,961,592		4,961,592	0	4,961,592	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,371,965		2,371,965	0	2,371,965	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	12,851,419		12,851,419	0	12,851,419	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	2,621,482		2,621,482		2,621,482	116.00
200.00	Subtotal (see instructions)	107,596,837	0	107,596,837	0	107,596,837	200.00
201.00	Less Observation Beds	2,371,965		2,371,965		2,371,965	201.00
202.00	Total (see instructions)	105,224,872	0	105,224,872	0	105,224,872	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/30/2016 1:46 pm	
			Title XVII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,533,894		13,533,894		30.00	
31.00	03100	INTENSIVE CARE UNIT	2,872,507		2,872,507		31.00	
43.00	04300	NURSERY	1,084,733		1,084,733		43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,341,621	28,131,748	48,473,369	0.242262	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,365,710	502,394	2,868,104	0.551112	52.00	
53.00	05300	ANESTHESIOLOGY	2,663,101	4,426,266	7,089,367	0.248194	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,402,724	13,257,643	15,660,367	0.312053	54.00	
54.01	03630	ULTRASOUND	350,364	3,229,767	3,580,131	0.122551	54.01	
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	662,505	10,650,120	11,312,625	0.085044	54.02	
54.06	05404	PET SCAN	0	806,411	806,411	0.173880	54.06	
57.00	05700	CT SCAN	4,717,466	23,104,661	27,822,127	0.036453	57.00	
58.00	05800	MRI	749,148	13,308,368	14,057,516	0.071634	58.00	
59.00	05900	CARDIAC CATHETERIZATION	889,207	6,234,769	7,123,976	0.123001	59.00	
60.00	06000	LABORATORY	6,376,573	11,379,135	17,755,708	0.248462	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	1,987,256	663,187	2,650,443	0.546061	65.00	
66.00	06600	PHYSICAL THERAPY	1,163,806	3,365,312	4,529,118	0.545748	66.00	
67.00	06700	OCCUPATIONAL THERAPY	372,368	1,089,031	1,461,399	0.357683	67.00	
69.00	06900	ELECTROCARDIOLOGY	1,850,732	8,335,551	10,186,283	0.134858	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	15,124	1,577,211	1,592,335	0.138447	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	37,081,512	20,839,705	57,921,217	0.304015	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	17,206,251	16,760,031	33,966,282	0.151621	73.00	
74.00	07400	RENAL DIALYSIS	90,958	14,743	105,701	0.688130	74.00	
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	76.00	
76.01	03650	VASCULAR LAB	245,055	2,593,827	2,838,882	0.236107	76.01	
76.03	03950	WOUND CARE	24,502	5,287,847	5,312,349	0.291511	76.03	
76.97	07697	CARDIAC REHABILITATION	3,868	593,767	597,635	0.265600	76.97	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,214	313,157	315,371	1.364054	90.00	
91.00	09100	EMERGENCY	3,745,331	18,795,690	22,541,021	0.220114	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	80,245	2,725,585	2,805,830	0.845370	92.00	
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	8,645,015	8,645,015		101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
116.00	11600	HOSPICE	0	1,103,458	1,103,458		116.00	
200.00		Subtotal (see instructions)	122,878,775	207,734,399	330,613,174		200.00	
201.00		Less Observation Beds					201.00	
202.00		Total (see instructions)	122,878,775	207,734,399	330,613,174		202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.242262	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.551112	52.00
53.00	05300 ANESTHESIOLOGY	0.248194	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.312053	54.00
54.01	03630 ULTRASOUND	0.122551	54.01
54.02	03450 NUCLEAR MEDICINE-DIAGNOSTIC	0.085044	54.02
54.06	05404 PET SCAN	0.173880	54.06
57.00	05700 CT SCAN	0.036453	57.00
58.00	05800 MRI	0.071634	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.123001	59.00
60.00	06000 LABORATORY	0.248462	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	0.546061	65.00
66.00	06600 PHYSICAL THERAPY	0.545748	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.357683	67.00
69.00	06900 ELECTROCARDIOLOGY	0.134858	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.138447	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.304015	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.151621	73.00
74.00	07400 RENAL DIALYSIS	0.688130	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	76.00
76.01	03650 VASCULAR LAB	0.236107	76.01
76.03	03950 WOUND CARE	0.291511	76.03
76.97	07697 CARDIAC REHABILITATION	0.265600	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1.364054	90.00
91.00	09100 EMERGENCY	0.220114	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.845370	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE		116.00
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: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet C
Part I
Date/Time Prepared:
11/30/2016 1:46 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	20,322,814		20,322,814	0	20,322,814	30.00
31.00	03100 INTENSIVE CARE UNIT	3,485,506		3,485,506	0	3,485,506	31.00
43.00	04300 NURSERY	486,276		486,276	0	486,276	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,743,277		11,743,277	0	11,743,277	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,580,646		1,580,646	0	1,580,646	52.00
53.00	05300 ANESTHESIOLOGY	1,759,541		1,759,541	0	1,759,541	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,886,865		4,886,865	0	4,886,865	54.00
54.01	03630 ULTRASOUND	438,748		438,748	0	438,748	54.01
54.02	03450 NUCLEAR MEDICINE-DIAGNOSTIC	962,068		962,068	0	962,068	54.02
54.06	05404 PET SCAN	140,219		140,219	0	140,219	54.06
57.00	05700 CT SCAN	1,014,194		1,014,194	0	1,014,194	57.00
58.00	05800 MRI	1,006,994		1,006,994	0	1,006,994	58.00
59.00	05900 CARDIAC CATHETERIZATION	876,255		876,255	0	876,255	59.00
60.00	06000 LABORATORY	4,411,611		4,411,611	0	4,411,611	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,447,304	0	1,447,304	0	1,447,304	65.00
66.00	06600 PHYSICAL THERAPY	2,471,756	0	2,471,756	0	2,471,756	66.00
67.00	06700 OCCUPATIONAL THERAPY	522,718	0	522,718	0	522,718	67.00
69.00	06900 ELECTROCARDIOLOGY	1,373,703		1,373,703	0	1,373,703	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	220,454		220,454	0	220,454	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	17,608,897		17,608,897	0	17,608,897	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,149,993		5,149,993	0	5,149,993	73.00
74.00	07400 RENAL DIALYSIS	72,736		72,736	0	72,736	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0		0	0	0	76.00
76.01	03650 VASCULAR LAB	670,280		670,280	0	670,280	76.01
76.03	03950 WOUND CARE	1,548,609		1,548,609	0	1,548,609	76.03
76.97	07697 CARDIAC REHABILITATION	158,732		158,732	0	158,732	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	430,183		430,183	0	430,183	90.00
91.00	09100 EMERGENCY	4,961,592		4,961,592	0	4,961,592	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	2,371,965		2,371,965	0	2,371,965	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	12,851,419		12,851,419	0	12,851,419	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	2,621,482		2,621,482		2,621,482	116.00
200.00	Subtotal (see instructions)	107,596,837	0	107,596,837	0	107,596,837	200.00
201.00	Less Observation Beds	2,371,965		2,371,965		2,371,965	201.00
202.00	Total (see instructions)	105,224,872	0	105,224,872	0	105,224,872	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/30/2016 1:46 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,533,894		13,533,894			30.00
31.00	03100	INTENSIVE CARE UNIT	2,872,507		2,872,507			31.00
43.00	04300	NURSERY	1,084,733		1,084,733			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,341,621	28,131,748	48,473,369	0.242262	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,365,710	502,394	2,868,104	0.551112	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,663,101	4,426,266	7,089,367	0.248194	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,402,724	13,257,643	15,660,367	0.312053	0.000000	54.00
54.01	03630	ULTRASOUND	350,364	3,229,767	3,580,131	0.122551	0.000000	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	662,505	10,650,120	11,312,625	0.085044	0.000000	54.02
54.06	05404	PET SCAN	0	806,411	806,411	0.173880	0.000000	54.06
57.00	05700	CT SCAN	4,717,466	23,104,661	27,822,127	0.036453	0.000000	57.00
58.00	05800	MRI	749,148	13,308,368	14,057,516	0.071634	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	889,207	6,234,769	7,123,976	0.123001	0.000000	59.00
60.00	06000	LABORATORY	6,376,573	11,379,135	17,755,708	0.248462	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	1,987,256	663,187	2,650,443	0.546061	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,163,806	3,365,312	4,529,118	0.545748	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	372,368	1,089,031	1,461,399	0.357683	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	1,850,732	8,335,551	10,186,283	0.134858	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,124	1,577,211	1,592,335	0.138447	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	37,081,512	20,839,705	57,921,217	0.304015	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,206,251	16,760,031	33,966,282	0.151621	0.000000	73.00
74.00	07400	RENAL DIALYSIS	90,958	14,743	105,701	0.688130	0.000000	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	0.000000	76.00
76.01	03650	VASCULAR LAB	245,055	2,593,827	2,838,882	0.236107	0.000000	76.01
76.03	03950	WOUND CARE	24,502	5,287,847	5,312,349	0.291511	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	3,868	593,767	597,635	0.265600	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,214	313,157	315,371	1.364054	0.000000	90.00
91.00	09100	EMERGENCY	3,745,331	18,795,690	22,541,021	0.220114	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	80,245	2,725,585	2,805,830	0.845370	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	8,645,015	8,645,015			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	1,103,458	1,103,458			116.00
200.00		Subtotal (see instructions)	122,878,775	207,734,399	330,613,174			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	122,878,775	207,734,399	330,613,174			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/30/2016 1:46 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
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
54.01	03630	ULTRASOUND	0.000000	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000	54.02
54.06	05404	PET SCAN	0.000000	54.06
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	76.00
76.01	03650	VASCULAR LAB	0.000000	76.01
76.03	03950	WOUND CARE	0.000000	76.03
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)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part I Date/Time Prepared: 11/30/2016 1:46 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,799,570	0	1,799,570	16,339	110.14	30.00
31.00	INTENSIVE CARE UNIT	304,945		304,945	1,700	179.38	31.00
43.00	NURSERY	31,432		31,432	1,491	21.08	43.00
200.00	Total (Lines 30-199)	2,135,947		2,135,947	19,530		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	8,860	975,840				
31.00	INTENSIVE CARE UNIT	1,137	203,955				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	9,997	1,179,795				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/30/2016 1:46 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,983,339	48,473,369	0.040916	20,341,621	832,298	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	187,296	2,868,104	0.065303	142,896	9,332	52.00
53.00	05300 ANESTHESIOLOGY	182,639	7,089,367	0.025762	1,327,518	34,200	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	795,427	15,660,367	0.050792	1,817,576	92,318	54.00
54.01	03630 ULTRASOUND	84,048	3,580,131	0.023476	206,514	4,848	54.01
54.02	03450 NUCLEAR MEDICINE-DIAGNOSTIC	99,313	11,312,625	0.008779	550,503	4,833	54.02
54.06	05404 PET SCAN	7,628	806,411	0.009459	0	0	54.06
57.00	05700 CT SCAN	86,429	27,822,127	0.003106	3,618,819	11,240	57.00
58.00	05800 MRI	147,617	14,057,516	0.010501	504,150	5,294	58.00
59.00	05900 CARDIAC CATHETERIZATION	88,394	7,123,976	0.012408	548,583	6,807	59.00
60.00	06000 LABORATORY	433,319	17,755,708	0.024404	4,225,155	103,111	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	161,297	2,650,443	0.060857	1,486,378	90,457	65.00
66.00	06600 PHYSICAL THERAPY	150,952	4,529,118	0.033329	814,147	27,135	66.00
67.00	06700 OCCUPATIONAL THERAPY	16,739	1,461,399	0.011454	250,524	2,870	67.00
69.00	06900 ELECTROCARDIOLOGY	191,994	10,186,283	0.018848	1,512,457	28,507	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	25,098	1,592,335	0.015762	10,177	160	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	551,163	57,921,217	0.009516	3,916,479	37,269	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	159,589	33,966,282	0.004698	10,747,228	50,490	73.00
74.00	07400 RENAL DIALYSIS	9,627	105,701	0.091078	90,958	8,284	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03650 VASCULAR LAB	98,104	2,838,882	0.034557	169,782	5,867	76.01
76.03	03950 WOUND CARE	137,990	5,312,349	0.025975	18,146	471	76.03
76.97	07697 CARDIAC REHABILITATION	17,543	597,635	0.029354	2,836	83	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	36,058	315,371	0.114335	500	57	90.00
91.00	09100 EMERGENCY	412,992	22,541,021	0.018322	2,467,603	45,211	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	210,035	2,805,830	0.074857	0	0	92.00
200.00	Total (lines 50-199)	6,274,630	303,373,567		54,770,550	1,401,142	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part III Date/Time Prepared: 11/30/2016 1:46 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,339	0.00	8,860	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,700	0.00	1,137	0		31.00
43.00	04300	NURSERY	1,491	0.00	0	0		43.00
200.00		Total (lines 30-199)	19,530		9,997	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/30/2016 1:46 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col . 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	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
54.01	03630	ULTRASOUND	0	0	0	0	0	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.02
54.06	05404	PET SCAN	0	0	0	0	0	54.06
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03650	VASCULAR LAB	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
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	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: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/30/2016 1:46 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	48,473,369	0.000000	0.000000	20,341,621	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,868,104	0.000000	0.000000	142,896	52.00
53.00	05300 ANESTHESIOLOGY	0	7,089,367	0.000000	0.000000	1,327,518	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,660,367	0.000000	0.000000	1,817,576	54.00
54.01	03630 ULTRASOUND	0	3,580,131	0.000000	0.000000	206,514	54.01
54.02	03450 NUCLEAR MEDICINE-DIAGNOSTIC	0	11,312,625	0.000000	0.000000	550,503	54.02
54.06	05404 PET SCAN	0	806,411	0.000000	0.000000	0	54.06
57.00	05700 CT SCAN	0	27,822,127	0.000000	0.000000	3,618,819	57.00
58.00	05800 MRI	0	14,057,516	0.000000	0.000000	504,150	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	7,123,976	0.000000	0.000000	548,583	59.00
60.00	06000 LABORATORY	0	17,755,708	0.000000	0.000000	4,225,155	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	2,650,443	0.000000	0.000000	1,486,378	65.00
66.00	06600 PHYSICAL THERAPY	0	4,529,118	0.000000	0.000000	814,147	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,461,399	0.000000	0.000000	250,524	67.00
69.00	06900 ELECTROCARDIOLOGY	0	10,186,283	0.000000	0.000000	1,512,457	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1,592,335	0.000000	0.000000	10,177	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	57,921,217	0.000000	0.000000	3,916,479	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	33,966,282	0.000000	0.000000	10,747,228	73.00
74.00	07400 RENAL DIALYSIS	0	105,701	0.000000	0.000000	90,958	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0.000000	0	76.00
76.01	03650 VASCULAR LAB	0	2,838,882	0.000000	0.000000	169,782	76.01
76.03	03950 WOUND CARE	0	5,312,349	0.000000	0.000000	18,146	76.03
76.97	07697 CARDIAC REHABILITATION	0	597,635	0.000000	0.000000	2,836	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	315,371	0.000000	0.000000	500	90.00
91.00	09100 EMERGENCY	0	22,541,021	0.000000	0.000000	2,467,603	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	2,805,830	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	303,373,567			54,770,550	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/30/2016 1:46 pm
Title XVIII		Hospital	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	20,007,955	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	1,655,262	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	3,650,628	0	54.00
54.01 03630 ULTRASOUND	0	1,216,439	0	54.01
54.02 03450 NUCLEAR MEDICINE-DIAGNOSTIC	0	5,487,982	0	54.02
54.06 05404 PET SCAN	0	0	0	54.06
57.00 05700 CT SCAN	0	8,837,110	0	57.00
58.00 05800 MRI	0	4,779,255	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	3,617,420	0	59.00
60.00 06000 LABORATORY	0	2,590,804	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	256,979	0	65.00
66.00 06600 PHYSICAL THERAPY	0	23,089	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	10,079	0	67.00
69.00 06900 ELECTROCARDIOLOGY	0	4,177,067	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	506,026	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	3,359,642	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,228,721	0	73.00
74.00 07400 RENAL DIALYSIS	0	3,132	0	74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	76.00
76.01 03650 VASCULAR LAB	0	1,424,603	0	76.01
76.03 03950 WOUND CARE	0	2,287,547	0	76.03
76.97 07697 CARDIAC REHABILITATION	0	378,051	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	28,476	0	90.00
91.00 09100 EMERGENCY	0	5,039,759	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	0	92.00
200.00 Total (lines 50-199)	0	74,566,026	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.242262	20,007,955	25	0	4,847,167	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.551112	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.248194	1,655,262	0	0	410,826	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.312053	3,650,628	1,265	2,154	1,139,189	54.00
54.01	03630 ULTRASOUND	0.122551	1,216,439	0	0	149,076	54.01
54.02	03450 NUCLEAR MEDICINE-DIAGNOSTIC	0.085044	5,487,982	0	207	466,720	54.02
54.06	05404 PET SCAN	0.173880	0	0	0	0	54.06
57.00	05700 CT SCAN	0.036453	8,837,110	0	7,717	322,139	57.00
58.00	05800 MRI	0.071634	4,779,255	0	2,295	342,357	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.123001	3,617,420	0	0	444,946	59.00
60.00	06000 LABORATORY	0.248462	2,590,804	969	138	643,716	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.546061	256,979	100	0	140,326	65.00
66.00	06600 PHYSICAL THERAPY	0.545748	23,089	0	0	12,601	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.357683	10,079	0	0	3,605	67.00
69.00	06900 ELECTROCARDIOLOGY	0.134858	4,177,067	0	0	563,311	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.138447	506,026	0	0	70,058	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.304015	3,359,642	0	62	1,021,382	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.151621	5,228,721	0	67,542	792,784	73.00
74.00	07400 RENAL DIALYSIS	0.688130	3,132	0	0	2,155	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03650 VASCULAR LAB	0.236107	1,424,603	0	0	336,359	76.01
76.03	03950 WOUND CARE	0.291511	2,287,547	0	248	666,845	76.03
76.97	07697 CARDIAC REHABILITATION	0.265600	378,051	0	0	100,410	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1.364054	28,476	0	0	38,843	90.00
91.00	09100 EMERGENCY	0.220114	5,039,759	0	0	1,109,322	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.845370	0	0	0	0	92.00
200.00	Subtotal (see instructions)		74,566,026	2,359	80,363	13,624,137	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		74,566,026	2,359	80,363	13,624,137	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	6	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	395	672	54.00
54.01	03630 ULTRASOUND	0	0	54.01
54.02	03450 NUCLEAR MEDICINE-DIAGNOSTIC	0	18	54.02
54.06	05404 PET SCAN	0	0	54.06
57.00	05700 CT SCAN	0	281	57.00
58.00	05800 MRI	0	164	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	241	34	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	55	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	19	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10,241	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03650 VASCULAR LAB	0	0	76.01
76.03	03950 WOUND CARE	0	72	76.03
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)	0	0	92.00
200.00	Subtotal (see instructions)	697	11,501	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	697	11,501	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/30/2016 1:46 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,339	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,339	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)		14,432	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		8,860	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		20,322,814	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		20,322,814	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)		20,322,814	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)		1,243.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,020,245	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)		11,020,245	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1		
		Title XVIII		Hospital		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	3,485,506	1,700	2,050.30	1,137	2,331,191	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)						12,284,524	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						25,635,960	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)						1,179,795	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						1,401,142	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						2,580,937	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						23,055,023	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						1,907	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,243.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,371,965	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140032		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/30/2016 1:46 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,799,570	20,322,814	0.088549	2,371,965	210,035	90.00
91.00	Nursing School cost	0	20,322,814	0.000000	2,371,965	0	91.00
92.00	Allied health cost	0	20,322,814	0.000000	2,371,965	0	92.00
93.00	All other Medical Education	0	20,322,814	0.000000	2,371,965	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/30/2016 1:46 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,984,362	30.00
31.00	03100	INTENSIVE CARE UNIT		2,044,300	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.242262	20,341,621	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.551112	142,896	52.00
53.00	05300	ANESTHESIOLOGY	0.248194	1,327,518	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.312053	1,817,576	54.00
54.01	03630	ULTRASOUND	0.122551	206,514	54.01
54.02	03450	NUCLEAR MEDICINE-DIAGNOSTIC	0.085044	550,503	54.02
54.06	05404	PET SCAN	0.173880	0	54.06
57.00	05700	CT SCAN	0.036453	3,618,819	57.00
58.00	05800	MRI	0.071634	504,150	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.123001	548,583	59.00
60.00	06000	LABORATORY	0.248462	4,225,155	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.546061	1,486,378	65.00
66.00	06600	PHYSICAL THERAPY	0.545748	814,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357683	250,524	67.00
69.00	06900	ELECTROCARDIOLOGY	0.134858	1,512,457	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.138447	10,177	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.304015	3,916,479	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.151621	10,747,228	73.00
74.00	07400	RENAL DIALYSIS	0.688130	90,958	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	76.00
76.01	03650	VASCULAR LAB	0.236107	169,782	76.01
76.03	03950	WOUND CARE	0.291511	18,146	76.03
76.97	07697	CARDIAC REHABILITATION	0.265600	2,836	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.364054	500	90.00
91.00	09100	EMERGENCY	0.220114	2,467,603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.845370	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		54,770,550	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)		54,770,550	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,533,430	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		15,493,372	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		257,317	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		601,728	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		127.79	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.69	30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.00	31.00
32.00	Sum of lines 30 and 31		19.69	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.55	33.00
34.00	Disproportionate share adjustment (see instructions)		277,872	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000096287	0.000091632	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	736,369	587,008	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	185,605	439,454	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	625,059		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	21,187,050		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		21,187,050	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,628,092	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		22,815,142	59.00
60.00	Primary payer payments		3,740	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,811,402	61.00
62.00	Deductibles billed to program beneficiaries		2,505,272	62.00
63.00	Coinurance billed to program beneficiaries		12,026	63.00
64.00	Allowable bad debts (see instructions)		515,183	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		334,869	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		20,628,973	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		122,755	70.93
70.94	HRR adjustment amount (see instructions)		-14,330	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/30/2016 1:46 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,737,398		71.00
71.01	Sequestration adjustment (see instructions)		414,748		71.01
72.00	Interim payments		20,202,504		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		120,146		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43,558		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0		100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0		102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0		104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		12,198	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		13,624,137	2.00
3.00	PPS payments		14,732,442	3.00
4.00	Outlier payment (see instructions)		52,081	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)		12,198	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		82,722	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)		82,722	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		82,722	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		70,524	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)		12,198	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)		14,784,523	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		129,636	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,035,108	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)		11,631,977	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)		11,631,977	30.00
31.00	Primary payer payments		70	31.00
32.00	Subtotal (line 30 minus line 31)		11,631,907	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)		661,293	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		429,840	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		12,061,747	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)		12,061,747	40.00
40.01	Sequestration adjustment (see instructions)		241,235	40.01
41.00	Interim payments		11,703,602	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		116,910	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: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
11/30/2016 1:46 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		20,157,300		11,692,141	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	02/09/2016	45,204	02/09/2016	11,461	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		45,204		11,461	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)		20,202,504		11,703,602	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		120,146		116,910	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		20,322,650		11,820,512	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: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		5,158	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		9,997	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		267	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		16,132	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		330,613,174	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		9,403,624	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)		458,725	8.00
9.00	Sequestration adjustment amount (see instructions)		9,175	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		449,550	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		444,988	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)		4,562	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 140032 Period: From 07/01/2015 To 06/30/2016 Worksheet G Date/Time Prepared: 11/30/2016 1:46 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	8,608,508	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	66,827,718	0	0	0	4.00
5.00	Other receivable	2,672,992	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-36,675,553	0	0	0	6.00
7.00	Inventory	4,574,480	0	0	0	7.00
8.00	Prepaid expenses	166,068	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	893,370	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	47,067,583	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,699,574	0	0	0	12.00
13.00	Land improvements	3,360,444	0	0	0	13.00
14.00	Accumulated depreciation	-2,024,848	0	0	0	14.00
15.00	Buildings	68,725,288	0	0	0	15.00
16.00	Accumulated depreciation	-29,778,541	0	0	0	16.00
17.00	Leasehold improvements	70,645	0	0	0	17.00
18.00	Accumulated depreciation	-65,560	0	0	0	18.00
19.00	Fixed equipment	15,074,960	0	0	0	19.00
20.00	Accumulated depreciation	-13,983,196	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	74,624,343	0	0	0	23.00
24.00	Accumulated depreciation	-62,059,593	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	2,546,766	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	59,190,282	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	294,771,307	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	7,749,888	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	302,521,195	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	408,779,060	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,052,635	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,270,434	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,697,576	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	9,312,000	0	0	0	43.00
44.00	Other current liabilities	24,562,055	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	48,894,700	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,027,366	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)	16,027,366	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	64,922,066	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	343,856,994				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)	343,856,994	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	408,779,060	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-1

Date/Time Prepared:
11/30/2016 1:46 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		348,757,095			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-6,447,272				2.00
3.00	Total (sum of line 1 and line 2)		342,309,823			0	3.00
4.00	RESTRICTED-TEMPORARY	1,369,037		0		0	4.00
5.00	RESTRICTED-PERMANENT	178,134		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)		1,547,171			0	10.00
11.00	Subtotal (line 3 plus line 10)		343,856,994			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		343,856,994			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	RESTRICTED-TEMPORARY		0				4.00
5.00	RESTRICTED-PERMANENT		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140032

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2016 1:46 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	14,896,970		14,896,970	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)	14,896,970		14,896,970	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,887,535		2,887,535	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,887,535		2,887,535	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,784,505		17,784,505	17.00
18.00	Ancillary services	94,126,891	182,926,916	277,053,807	18.00
19.00	Outpatient services	3,875,874	27,426,455	31,302,329	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		8,645,015	8,645,015	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	0	1,103,458	1,103,458	26.00
27.00	PROFESSIONAL FEES	622,177	5,325,212	5,947,389	27.00
27.01	OTHER NONREIMBURSEABLE CC	0	4,054,038	4,054,038	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	116,409,447	229,481,094	345,890,541	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		129,598,134		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)		129,598,134		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/30/2016 1:46 pm
		1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	345,890,541		1.00
2.00	Less contractual allowances and discounts on patients' accounts	215,625,442		2.00
3.00	Net patient revenues (line 1 minus line 2)	130,265,099		3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	129,598,134		4.00
5.00	Net income from service to patients (line 3 minus line 4)	666,965		5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc	0		6.00
7.00	Income from investments	-9,119,898		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 AND NONOPERATING INC	2,005,661		24.00
25.00	Total other income (sum of lines 6-24)	-7,114,237		25.00
26.00	Total (line 5 plus line 25)	-6,447,272		26.00
27.00	OTHER EXPENSES (SPECIFY)	0		27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0		28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,447,272		29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140032

Period: From 07/01/2015

Worksheet H

HHA CCN: 147661

To 06/30/2016

Date/Time Prepared: 11/30/2016 1:46 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	184,207	184,207	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	799,397	2,458	0	300,319	1,102,174	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	3,139,470	207,923	0	0	3,347,393	6.00
7.00	Physical Therapy	380,469	50,462	450,115	0	881,046	7.00
8.00	Occupational Therapy	289,517	38,754	0	0	328,271	8.00
9.00	Speech Pathology	32,540	7,763	0	0	40,303	9.00
10.00	Medical Social Services	85,311	2,138	0	0	87,449	10.00
11.00	Home Health Aide	213,398	46,413	0	0	259,811	11.00
12.00	Supplies (see instructions)	0	0	0	357,471	357,471	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	4,940,102	355,911	450,115	841,997	6,588,125	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	184,207	0	184,207	3.00	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	0	1,102,174	-713	1,101,461	5.00	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	3,347,393	0	3,347,393	6.00	6.00
7.00	Physical Therapy	0	881,046	0	881,046	7.00	7.00
8.00	Occupational Therapy	0	328,271	0	328,271	8.00	8.00
9.00	Speech Pathology	0	40,303	0	40,303	9.00	9.00
10.00	Medical Social Services	0	87,449	0	87,449	10.00	10.00
11.00	Home Health Aide	0	259,811	0	259,811	11.00	11.00
12.00	Supplies (see instructions)	-247,852	109,619	0	109,619	12.00	12.00
13.00	Drugs	0	0	0	0	13.00	13.00
14.00	DME	0	0	0	0	14.00	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	15.00	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00	17.00
18.00	Clinic	0	0	0	0	18.00	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00	19.00
20.00	Day Care Program	0	0	0	0	20.00	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00	21.00
22.00	Homemaker Service	0	0	0	0	22.00	22.00
23.00	All Others (specify)	0	0	0	0	23.00	23.00
24.00	Total (sum of lines 1-23)	-247,852	6,340,273	-713	6,339,560	24.00	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140032	Period: From 07/01/2015	Worksheet H-1 Part I
		HHA CCN: 147661	To 06/30/2016	Date/Time Prepared: 11/30/2016 1:46 pm
			Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
	0	1.00	2.00	3.00	4.00	4A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	184,207	0	0	184,207	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	1,101,461	0	0	184,207	0	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	3,347,393	0	0	0	3,347,393	6.00
7.00	Physical Therapy	881,046	0	0	0	881,046	7.00
8.00	Occupational Therapy	328,271	0	0	0	328,271	8.00
9.00	Speech Pathology	40,303	0	0	0	40,303	9.00
10.00	Medical Social Services	87,449	0	0	0	87,449	10.00
11.00	Home Health Aide	259,811	0	0	0	259,811	11.00
12.00	Supplies (see instructions)	109,619	0	0	0	109,619	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	6,339,560	0	0	184,207	0	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	1,285,668					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	851,548	4,198,941				6.00
7.00	Physical Therapy	224,131	1,105,177				7.00
8.00	Occupational Therapy	83,510	411,781				8.00
9.00	Speech Pathology	10,253	50,556				9.00
10.00	Medical Social Services	22,246	109,695				10.00
11.00	Home Health Aide	66,094	325,905				11.00
12.00	Supplies (see instructions)	27,886	137,505				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		6,339,560				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 140032 HHA CCN: 147661	Period: From 07/01/2015 To 06/30/2016	Worksheet H-1 Part II Date/Time Prepared: 11/30/2016 1:46 pm PPS
			Home Health Agency I	

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	3,481			0		1.00
2.00	Capital Related - Movable Equipment		159,648		0		2.00
3.00	Plant Operation & Maintenance	0	0	3,481	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	3,481	159,648	3,481	0	-1,285,668	5,053,892
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	3,347,393
7.00	Physical Therapy	0	0	0	0	0	881,046
8.00	Occupational Therapy	0	0	0	0	0	328,271
9.00	Speech Pathology	0	0	0	0	0	40,303
10.00	Medical Social Services	0	0	0	0	0	87,449
11.00	Home Health Aide	0	0	0	0	0	259,811
12.00	Supplies (see instructions)	0	0	0	0	0	109,619
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	3,481	159,648	3,481	0	-1,285,668	5,053,892
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	184,207	0		1,285,668
26.00	Unit Cost Multiplier	0.000000	0.000000	52.917840	0.000000		0.254392

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140032
HHA CCN: 147661

Period:
From 07/01/2015
To 06/30/2016

Worksheet H-2
Part I
Date/Time Prepared:
11/30/2016 1:46 pm
PPS

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00				
1.00	Administrative and General	0	22,429	107,084	251,659	381,172	117,571	1.00
2.00	Skilled Nursing Care	4,198,941	0	0	988,339	5,187,280	1,599,995	2.00
3.00	Physical Therapy	1,105,177	0	0	119,776	1,224,953	377,832	3.00
4.00	Occupational Therapy	411,781	0	0	91,143	502,924	155,125	4.00
5.00	Speech Pathology	50,556	0	0	10,244	60,800	18,754	5.00
6.00	Medical Social Services	109,695	0	0	26,857	136,552	42,119	6.00
7.00	Home Health Aide	325,905	0	0	67,180	393,085	121,245	7.00
8.00	Supplies (see instructions)	137,505	0	0	0	137,505	42,413	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	6,339,560	22,429	107,084	1,555,198	8,024,271	2,475,054	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,022	110,536	145,405	31,697	0	120,913	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,022	110,536	145,405	31,697	0	120,913	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140032
HHA CCN: 147661

Period:
From 07/01/2015
To 06/30/2016

Worksheet H-2
Part I
Date/Time Prepared:
11/30/2016 1:46 pm
PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Home Health Agency I SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	453,244	7,000	1,482,277	0	0	2,850,837	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	6,787,275	2.00
3.00	Physical Therapy	0	0	0	0	0	1,602,785	3.00
4.00	Occupational Therapy	0	0	0	0	0	658,049	4.00
5.00	Speech Pathology	0	0	0	0	0	79,554	5.00
6.00	Medical Social Services	0	0	0	0	0	178,671	6.00
7.00	Home Health Aide	0	0	0	0	0	514,330	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	179,918	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	453,244	7,000	1,482,277	0	0	12,851,419	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	2,850,837					1.00
2.00	Skilled Nursing Care	0	6,787,275	1,934,829	8,722,104			2.00
3.00	Physical Therapy	0	1,602,785	456,901	2,059,686			3.00
4.00	Occupational Therapy	0	658,049	187,588	845,637			4.00
5.00	Speech Pathology	0	79,554	22,678	102,232			5.00
6.00	Medical Social Services	0	178,671	50,933	229,604			6.00
7.00	Home Health Aide	0	514,330	146,619	660,949			7.00
8.00	Supplies (see instructions)	0	179,918	51,289	231,207			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	12,851,419	2,850,837	12,851,419			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.285067				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140032
HHA CCN: 147661

Period:
From 07/01/2015
To 06/30/2016

Worksheet H-2
Part II
Date/Time Prepared:
11/30/2016 1:46 pm
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (MAINT. HOURS)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	3,481	159,648	799,397	0	381,172	61	1.00
2.00 Skilled Nursing Care	0	0	3,139,470	0	5,187,280	0	2.00
3.00 Physical Therapy	0	0	380,469	0	1,224,953	0	3.00
4.00 Occupational Therapy	0	0	289,517	0	502,924	0	4.00
5.00 Speech Pathology	0	0	32,540	0	60,800	0	5.00
6.00 Medical Social Services	0	0	85,311	0	136,552	0	6.00
7.00 Home Health Aide	0	0	213,398	0	393,085	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	137,505	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	3,481	159,648	4,940,102		8,024,271	61	20.00
21.00 Total cost to be allocated	22,429	107,084	1,555,198		2,475,054	1,022	21.00
22.00 Unit cost multiplier	6.443263	0.670751	0.314811		0.308446	16.754098	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	3,481	128,639	30,853	0	4,538	162,662	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	3,481	128,639	30,853	0	4,538	162,662	20.00
21.00 Total cost to be allocated	110,536	145,405	31,697	0	120,913	453,244	21.00
22.00 Unit cost multiplier	31.754094	1.130334	1.027356	0.000000	26.644557	2.786416	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140032
HHA CCN: 147661

Period:
From 07/01/2015
To 06/30/2016

Worksheet H-2
Part II
Date/Time Prepared:
11/30/2016 1:46 pm
PPS

Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	Home Health Agency I	
	14.00	15.00	16.00	17.00		
1.00 Administrative and General	286,178	121,518	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	286,178	121,518	0	0		20.00
21.00 Total cost to be allocated	7,000	1,482,277	0	0		21.00
22.00 Unit cost multiplier	0.024460	12.198004	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140032 HHA CCN: 147661	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part I Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVII I	Home Health Agency I	PPS

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

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	8,722,104		8,722,104	41,027	212.59	1.00
2.00	Physical Therapy	3.00	2,059,686	0	2,059,686	12,235	168.34	2.00
3.00	Occupational Therapy	4.00	845,637	0	845,637	4,511	187.46	3.00
4.00	Speech Pathology	5.00	102,232	0	102,232	565	180.94	4.00
5.00	Medical Social Services	6.00	229,604		229,604	496	462.91	5.00
6.00	Home Health Aide	7.00	660,949		660,949	4,046	163.36	6.00
7.00	Total (sum of lines 1-6)		12,620,212	0	12,620,212	62,880		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits		Total Charges (From HHA Records)	Ratio (col. 3 ÷ col. 4)	
			Part A	Part B			
				Not Subject to Deductibles & Coinsurance			Subject to Deductibles
0	1.00	2.00	3.00	4.00	5.00		

Limitation Cost Computation							
8.00	Skilled Nursing Care		41180	0	19,454		8.00
9.00	Physical Therapy		41180	0	7,849		9.00
10.00	Occupational Therapy		41180	0	3,009		10.00
11.00	Speech Pathology		41180	0	322		11.00
12.00	Medical Social Services		41180	0	280		12.00
13.00	Home Health Aide		41180	0	3,131		13.00
14.00	Total (sum of lines 8-13)			0	34,045		14.00

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

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	231,207	0	231,207	59,272	3.900779	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part A	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	19,454		0	4,135,726		1.00
2.00	Physical Therapy	0	7,849		0	1,321,301		2.00
3.00	Occupational Therapy	0	3,009		0	564,067		3.00
4.00	Speech Pathology	0	322		0	58,263		4.00
5.00	Medical Social Services	0	280		0	129,615		5.00
6.00	Home Health Aide	0	3,131		0	511,480		6.00
7.00	Total (sum of lines 1-6)	0	34,045		0	6,720,452		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 140032 HHA CCN: 147661	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part I Date/Time Prepared: 11/30/2016 1:46 pm PPS
			Title XVII	Home Health Agency I	

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

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

Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	16.00

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

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

Cost Per Visit Computation			
1.00	Skilled Nursing Care	4,135,726	1.00
2.00	Physical Therapy	1,321,301	2.00
3.00	Occupational Therapy	564,067	3.00
4.00	Speech Pathology	58,263	4.00
5.00	Medical Social Services	129,615	5.00
6.00	Home Health Aide	511,480	6.00
7.00	Total (sum of lines 1-6)	6,720,452	7.00

Cost Center Description		
		12.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140032 HHA CCN: 147661	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part II Date/Time Prepared: 11/30/2016 1:46 pm PPS
		Title XVIII	Home Health Agency I	

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.545748	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.357683	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.304015	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.151621	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140032 HHA CCN: 147661	Period: From 07/01/2015 To 06/30/2016	Worksheet H-4 Part I-II Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	4,372,308	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	261,192	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	46,036	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	41,776	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	101,038	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	12,545	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	4,834,895	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	4,834,895	24.00
25.00	Coinurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	4,834,895	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	4,834,895	29.00
30.00	OTHER PSR ADJUSTMENTS	0	-2,108	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	4,832,787	31.00
31.01	Sequestration adjustment (see instructions)	0	96,657	31.01
32.00	Interim payments (see instructions)	0	4,736,130	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet H-5
	HHA CCN: 147661	Home Health Agency I	Date/Time Prepared: 11/30/2016 1:46 pm PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		4,736,130	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		4,736,130	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		4,736,130	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140032	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/30/2016 1:46 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,593,627	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		34,465	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		45.23	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,628,092	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00