

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/29/2016 11:55 am
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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: 11/29/2016	Time: 11:55 am
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 HARVARD MEMORIAL HOSPITAL (141335) 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 XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-79,435	-206,081	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	-1	-2,770		0	7.00
8.00 NURSING FACILITY	0				0	8.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	-79,436	-208,851	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/29/2016 11:44 am
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 901 GRANT STREET	PO Box:		Zip Code: 60033-		County: MC HENRY				1.00
2.00	City: HARVARD	State: IL								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	
		Hospital and Hospital-Based Component Identification:								
3.00	Hospital	HARVARD MEMORIAL HOSPITAL	141335	16974	1	01/01/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	CARE CENTER	146014	99914		01/01/2002	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/29/2016 11:44 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0			37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N			37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N		N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N		N	40.00	
		V	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	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	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	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		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.					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	5.00		
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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00	
		Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00				
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	
		Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				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.			Y	N	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	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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		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		901041		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: MERCY HOME OFFICE	Contractor's Name: NGS		Contractor's Number: 00450			
142.00	Street: 1000 MINERAL POINT AVE	PO Box:					
143.00	City: JANESVILLE	State: WI		Zip Code: 53547			
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	Y		Y		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC					N	
161.10	CORF			N		N	
						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	
		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)					0168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/29/2016 11:44 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10/01/2014	09/30/2015	170.00
			1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/29/2016 11:44 am		
			Y/N	Date		
			1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPLETED BY ALL HOSPITALS						
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00	
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00	
			Y/N	Type	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00	
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00	
				Y/N		
				1.00		
Bad Debts						
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00	
Bed Complement						
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00	
			Part A		Part B	
			Y/N	Date	Y/N	Date
			1.00	2.00	3.00	4.00
PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/26/2016	Y	10/26/2016	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: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/29/2016 11:44 am	
		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		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		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.	KELLY	BETH		41.00
42.00	Enter the employer/company name of the cost report preparer.	WI PFLI			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	414-259-6738	KBETH@WI PFLI . COM		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.	MANAGER, HEALTHCARE	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: 141335

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2016 11:44 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / 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	10	3,660	32,274.00	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)		10	3,660	32,274.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,098	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	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)		13	4,758	32,274.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	13	4,616		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE	46.00	32	11,854			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		58				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: 141335

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2016 11:44 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	666	23	1,196			1.00
2.00 HMO and other (see instructions)	35	100				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	666	23	1,196			7.00
8.00 INTENSIVE CARE UNIT	18	0	34			8.00
9.00 CORONARY CARE UNIT	0	0	0			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		0	0			13.00
14.00 Total (see instructions)	684	23	1,230	0.00	152.77	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	1,863	0	2,530	0.00	13.79	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE			6,497	0.00	11.79	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	178.35	27.00
28.00 Observation Bed Days		0	415			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141335

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

Worksheet S-3
Part I
Date/Time Prepared:
11/29/2016 11:44 am

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	211	6	408	1.00
2.00 HMO and other (see instructions)				9	39		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		211	6	408	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0		0	0	0	17.00
18.00 SUBPROVIDER	0.00	0			0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY	0.00						20.00
21.00 OTHER LONG TERM CARE	0.00					0	21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141335

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

Worksheet S-7

Date/Time Prepared:
11/29/2016 11:44 am

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	90	0	90	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	54	0	54	14.00
15.00	RVC	97	0	97	15.00
16.00	RVB	301	0	301	16.00
17.00	RVA	452	0	452	17.00
18.00	RHC	208	0	208	18.00
19.00	RHB	154	0	154	19.00
20.00	RHA	283	0	283	20.00
21.00	RMC	14	0	14	21.00
22.00	RMB	7	0	7	22.00
23.00	RMA	36	0	36	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	14	0	14	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	26	0	26	35.00
36.00	HB1	37	0	37	36.00
37.00	LE2	13	0	13	37.00
38.00	LE1	13	0	13	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	1	0	1	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	5	0	5	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	3	0	3	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	14	0	14	49.00
50.00	CC1	1	0	1	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	9	0	9	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	15	0	15	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141335

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

Worksheet S-7

Date/Time Prepared:
11/29/2016 11:44 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	14	0	14	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	2	0	2	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,863	0	1,863	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	918,356			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/29/2016 11:44 am
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				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)		0.343521		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,629,818		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		11,382,825		6.00
7.00	Medicaid cost (line 1 times line 6)		3,910,239		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		2,280,421		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		11,482		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,280,421		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	50,960	30,700	81,660	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	17,506	10,546	28,052	21.00
22.00	Partial payment by patients approved for charity care	70	0	70	22.00
23.00	Cost of charity care (line 21 minus line 22)	17,436	10,546	27,982	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,528,610	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			0	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			1,528,610	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			525,110	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			553,092	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,833,513	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141335

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

Worksheet A

Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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	NEW CAP REL COSTS-BLDG & FIXT	0	0	1,395,113	1,395,113	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,275,639	-1,395,113	880,526	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,620,990	0	1,620,990	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	811,947	1,514,377	-345,065	1,981,259	5.00
7.00	00700	OPERATION OF PLANT	0	816,032	0	816,032	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	-9,186	0	-9,186	8.00
9.00	00900	HOUSEKEEPING	185,522	73,971	259,493	259,493	9.00
10.00	01000	DIETARY	411,945	214,633	626,578	626,578	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	649,356	52,153	701,509	845,737	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,960	24,376	191,336	291,778	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	884,002	199,230	1,083,232	1,083,232	30.00
31.00	03100	INTENSIVE CARE UNIT	122,723	12,647	135,370	135,370	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	961,858	961,858	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	1,657,329	518,267	2,175,596	762,864	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	620,584	1,731,780	2,352,364	1,734,066	50.00
51.00	05100	RECOVERY ROOM	461,132	107,915	569,047	569,047	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	84,612	1,359,666	1,444,278	1,444,278	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	765,175	487,881	1,253,056	1,285,365	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	557,493	646,789	1,204,282	1,230,667	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	181,379	57,425	238,804	238,852	65.00
66.00	06600	PHYSICAL THERAPY	174,106	21,557	195,663	354,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	165,630	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	11,223	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	63,999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	618,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	217,089	587,107	804,196	882,726	73.00
76.97	07697	CARDIAC REHABILITATION	31,007	4,507	35,514	49,790	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	696,587	1,864,938	2,561,525	2,561,525	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,678,948	14,182,694	22,861,642	22,861,642	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	8,678,948	14,182,694	22,861,642	22,861,642	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141335

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

Worksheet A
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-277,983	1,117,130	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-170,021	710,505	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	174,842	1,795,832	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,314,119	3,295,378	5.00
7.00	00700	OPERATION OF PLANT	100,861	916,893	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	-9,186	8.00
9.00	00900	HOUSEKEEPING	16,443	275,936	9.00
10.00	01000	DIETARY	-94,492	532,086	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,147	849,884	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	33,932	325,710	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	11,666	1,094,898	30.00
31.00	03100	INTENSIVE CARE UNIT	0	135,370	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	-5,242	956,616	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	-54,311	708,553	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-239	1,733,827	50.00
51.00	05100	RECOVERY ROOM	0	569,047	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,134,150	310,128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,080	1,304,445	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,230,667	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	238,852	65.00
66.00	06600	PHYSICAL THERAPY	0	354,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	165,630	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,223	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	63,999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	618,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	882,726	73.00
76.97	07697	CARDIAC REHABILITATION	-622	49,168	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-26,111	2,535,414	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-88,081	22,773,561	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-88,081	22,773,561	200.00

RECLASSIFICATIONS

Provider CCN: 141335

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

Worksheet A-6

Date/Time Prepared:
11/29/2016 11:44 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - SNF/LONG TERM CARE EXP RECLASS					
1.00	SKILLED NURSING FACILITY	44.00	732,726	229,132	1.00
	TOTALS		732,726	229,132	
B - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	618,298	1.00
	0		0	618,298	
C - MANAGER/DIRECTOR RECLASS					
1.00	NURSING ADMINISTRATION	13.00	134,698	9,530	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	93,805	6,637	2.00
3.00	OTHER LONG TERM CARE	46.00	80,429	5,690	3.00
4.00	CARDIAC REHABILITATION	76.97	13,333	943	4.00
	TOTALS		322,265	22,800	
D - INTERCOMPANY TRANSACTIONS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	61,943	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	494,633	0	2.00
3.00	OPERATION OF PLANT	7.00	162,559	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	9,048	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	42,171	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	100,926	0	6.00
	TOTALS		862,232	9,048	
E - SNF AND LTC RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	25,509	6,800	1.00
2.00	LABORATORY	60.00	20,832	5,553	2.00
3.00	RESPIRATORY THERAPY	65.00	29	19	3.00
4.00	PHYSICAL THERAPY	66.00	96,737	62,132	4.00
5.00	OCCUPATIONAL THERAPY	67.00	100,854	64,776	5.00
6.00	SPEECH PATHOLOGY	68.00	6,834	4,389	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	50,530	13,469	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	62,003	16,527	8.00
	0		363,328	173,665	
F - DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,395,113	1.00
	TOTALS		0	1,395,113	
G - LOCUM SALARY RECLASS					
1.00	ANESTHESIOLOGY	53.00	1,188,158	0	1.00
2.00	EMERGENCY	91.00	1,383,687	0	2.00
	TOTALS		2,571,845	0	
500.00	Grand Total: Increases		4,852,396	2,448,056	500.00

RECLASSIFICATIONS

Provider CCN: 141335

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

Worksheet A-6

Date/Time Prepared:
11/29/2016 11:44 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - SNF/LONG TERM CARE EXP RECLASS						
1.00	OTHER LONG TERM CARE	46.00	732,726	229,132	0	1.00
	TOTALS		732,726	229,132		
B - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	618,298	0	1.00
	0		0	618,298		
C - MANAGER/DIRECTOR RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	322,265	22,800	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		322,265	22,800		
D - INTERCOMPANY TRANSACTIONS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	61,943	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	494,633	0	2.00
3.00	OPERATION OF PLANT	7.00	0	162,559	0	3.00
4.00	NURSING ADMINISTRATION	13.00	9,048	0	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,171	0	5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	100,926	0	6.00
	TOTALS		9,048	862,232		
E - SNF AND LTC RECLASS						
1.00	OTHER LONG TERM CARE	46.00	363,328	173,665	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
	0		363,328	173,665		
F - DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,395,113	9	1.00
	TOTALS		0	1,395,113		
G - LOCUM SALARY RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	1,188,158	0	1.00
2.00	EMERGENCY	91.00	0	1,383,687	0	2.00
	TOTALS		0	2,571,845		
500.00	Grand Total: Decreases		1,427,367	5,873,085		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141335

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

Worksheet A-7
Part I
Date/Time Prepared:
11/29/2016 11:44 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	222,604	0	0	0	1.00
2.00	Land Improvements	728,581	73,098	0	73,098	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	20,394,665	154,747	0	154,747	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	12,837,116	363,428	0	363,428	6.00
7.00	HIT designated Assets	1,470,955	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,653,921	591,273	0	591,273	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,653,921	591,273	0	591,273	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	222,604	0			1.00
2.00	Land Improvements	801,679	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	20,549,412	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	13,200,544	0			6.00
7.00	HIT designated Assets	1,470,955	0			7.00
8.00	Subtotal (sum of lines 1-7)	36,245,194	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	36,245,194	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141335

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

Worksheet A-7
Part II
Date/Time Prepared:
11/29/2016 11:44 am

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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,275,639	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,275,639	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	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,275,639				2.00
3.00	Total (sum of lines 1-2)	0	2,275,639				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141335

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

Worksheet A-7
Part III
Date/Time Prepared:
11/29/2016 11:44 am

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	NEW CAP REL COSTS-BLDG & FIXT	21,573,695	0	21,573,695	0.595215	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	14,671,499	0	14,671,499	0.404785	0	2.00
3.00	Total (sum of lines 1-2)	36,245,194	0	36,245,194	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,395,113	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	710,505	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,105,618	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	NEW CAP REL COSTS-BLDG & FIXT	-277,983	0	0	0	1,117,130	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	710,505	2.00
3.00	Total (sum of lines 1-2)	-277,983	0	0	0	1,827,635	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141335

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

Worksheet A-8

Date/Time Prepared:
11/29/2016 11:44 am

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		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,704	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,559,034			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	2,608,129			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-106,937	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-170	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant				0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-210,136	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141335

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

Worksheet A-8

Date/Time Prepared:
11/29/2016 11:44 am

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		
33.00 OTHER OPERATING REVENUE	B	-2,563	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00 ILLINOIS UNALLOWABLE REAL ESTATE TAX	A	-7,590	OPERATION OF PLANT	7.00	0	34.00
35.00 LOBBYING EXPENSE	A	-11,338	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 WELLNESS CENTER REVENUE	B	-622	CARDIAC REHABILITATION	76.97	0	36.00
37.00 HOSPITAL TAX	A	-453,656	ADMINISTRATIVE & GENERAL	5.00	0	37.00
39.00 CASH DISCOUNTS	B	-95	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 HOME OFFICE INTEREST EXPENSE	A	-276,279	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	40.00
41.00 RENTAL INCOME	B	-533	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00 SNF TAX	A	-6,924	SKILLED NURSING FACILITY	44.00	0	42.00
43.00 CARE CENTER TAX	A	-58,629	OTHER LONG TERM CARE	46.00	0	43.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-88,081				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: 141335

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

Worksheet A-8-1

Date/Time Prepared: 11/29/2016 11:44 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE EMPLOYEE BENEFIT	256,855	82,013	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN & GENERAL	2,713,604	931,300	2.00
3.00	7.00	OPERATION OF PLANT	HOME OFFICE OPERATION OF PLA	108,451	0	3.00
4.00	13.00	NURSING ADMINISTRATION	HOME OFFICE NURSING ADMIN	4,147	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE MEDICAL RECORDS	34,102	0	4.01
4.02	30.00	ADULTS & PEDIATRICS	HOME OFFICE ADULTS & PEDS	11,666	0	4.02
4.03	44.00	SKILLED NURSING FACILITY	HOME OFFICE SKILLED NURSING	1,682	0	4.03
4.04	46.00	OTHER LONG TERM CARE	HOME OFFICE OTHER LTC	4,318	0	4.04
4.05	53.00	ANESTHESIOLOGY	HOME OFFICE ANESTHESIOLOGY	33,334	0	4.05
4.06	91.00	EMERGENCY	HOME OFFICE EMERGENCY	75,641	0	4.06
4.07	2.00	NEW CAP REL COSTS-MVBLE EQUI	HIT ASSETS FROM JVL	250,251	210,136	4.07
4.08	53.00	ANESTHESIOLOGY	PHYSICIAN BENEFITS FROM JANE	104,996	0	4.08
4.09	91.00	EMERGENCY	PHYSICIAN BENEFITS FROM JANE	122,274	0	4.09
4.10	9.00	HOUSEKEEPING	MANAGER DIRECTOR ALLOCATION	4,548	0	4.10
4.11	10.00	DIETARY	MANAGER DIRECTOR ALLOCATION	12,445	0	4.11
4.12	9.00	HOUSEKEEPING	MANAGER DIRECTOR ALLOCATION	11,895	0	4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC	MANAGER DIRECTOR ALLOCATION	19,080	0	4.13
4.14	53.00	ANESTHESIOLOGY	MALPRACTICE ADJ	13,571	0	4.14
4.15	91.00	EMERGENCY	MALPRACTICE ADJ	48,718	0	4.15
5.00	0			3,831,578	1,223,449	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	B		0.00	MERCY HOME OFFI	100.00	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: 141335

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

Worksheet A-8-1

Date/Time Prepared:
11/29/2016 11:44 am

	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	174,842	0		1.00
2.00	1,782,304	0		2.00
3.00	108,451	0		3.00
4.00	4,147	0		4.00
4.01	34,102	0		4.01
4.02	11,666	0		4.02
4.03	1,682	0		4.03
4.04	4,318	0		4.04
4.05	33,334	0		4.05
4.06	75,641	0		4.06
4.07	40,115	9		4.07
4.08	104,996	0		4.08
4.09	122,274	0		4.09
4.10	4,548	0		4.10
4.11	12,445	0		4.11
4.12	11,895	0		4.12
4.13	19,080	0		4.13
4.14	13,571	0		4.14
4.15	48,718	0		4.15
5.00	2,608,129			5.00

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

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

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

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

6.00	HEALTH SYSTEM		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: 141335

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

Worksheet A-8-2

Date/Time Prepared:
11/29/2016 11:44 am

	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	50.00	AGGREGATE-OPERATING ROOM	43,795	239	43,556	0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	16,334	0	16,334	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,286,051	1,286,051	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1,497,690	272,744	1,224,946	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,843,870	1,559,034	1,284,836	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	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	239		1.00
2.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,286,051		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	272,744		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,559,034		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141335

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,117,130	1,117,130			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	710,505		710,505		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,795,832	0	0	1,795,832	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,295,378	133,950	11,365	358,089	5.00
7.00 00700	OPERATION OF PLANT	916,893	222,185	131,281	40,859	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	-9,186	12,894	1,274	0	8.00
9.00 00900	HOUSEKEEPING	275,936	5,079	1,182	30,532	9.00
10.00 01000	DIETARY	532,086	34,370	13,044	67,796	10.00
11.00 01100	CAFETERIA	0	18,476	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	849,884	6,196	1,377	128,205	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	325,710	23,792	0	45,991	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,094,898	93,133	12,832	147,405	30.00
31.00 03100	INTENSIVE CARE UNIT	135,370	25,648	398	20,197	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	956,616	66,605	6,899	120,866	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	708,553	114,413	17,717	106,320	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,733,827	109,348	174,405	102,097	50.00
51.00 05100	RECOVERY ROOM	569,047	4,465	2,231	75,891	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	310,128	0	9,486	20,580	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,304,445	31,886	253,375	137,068	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,230,667	21,309	16,188	95,178	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	238,852	18,001	14,910	29,855	65.00
66.00 06600	PHYSICAL THERAPY	354,532	50,390	2,959	44,574	66.00
67.00 06700	OCCUPATIONAL THERAPY	165,630	0	0	16,598	67.00
68.00 06800	SPEECH PATHOLOGY	11,223	0	0	1,125	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,999	0	23,250	8,316	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	618,298	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	882,726	7,535	1,600	62,542	73.00
76.97 07697	CARDIAC REHABILITATION	49,168	6,977	8,112	7,297	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	2,535,414	20,276	6,620	128,451	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,773,561	1,026,928	710,505	1,795,832	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	90,202	0	0	192.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	22,773,561	1,117,130	710,505	1,795,832	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141335

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,798,782				5.00
7.00	00700	OPERATION OF PLANT	262,508	1,573,726			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	997	26,665	32,644		8.00
9.00	00900	HOUSEKEEPING	62,609	10,504	0	385,842	9.00
10.00	01000	DIETARY	129,590	71,077	0	17,848	10.00
11.00	01100	CAFETERIA	3,699	38,208	0	9,594	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	197,332	12,813	0	3,217	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,178	49,202	0	12,355	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	269,926	192,596	9,600	48,362	30.00
31.00	03100	INTENSIVE CARE UNIT	36,359	53,040	91	13,319	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	230,430	137,738	2,891	34,587	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	189,592	236,605	7,424	59,414	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	424,364	226,129	7,210	56,783	50.00
51.00	05100	RECOVERY ROOM	130,458	9,234	767	2,319	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	68,108	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	345,704	65,940	1,855	16,558	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	272,944	44,066	0	11,065	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	60,385	37,226	0	9,348	65.00
66.00	06600	PHYSICAL THERAPY	90,582	104,205	1,022	26,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,482	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,472	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,132	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	123,784	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	191,073	15,583	0	3,913	73.00
76.97	07697	CARDIAC REHABILITATION	14,325	14,429	0	3,623	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	538,690	41,930	1,670	10,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,780,723	1,387,190	32,530	339,001	865,811
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,059	186,536	114	46,841	192.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,798,782	1,573,726	32,644	385,842	865,811

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141335

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		11.00	12.00	13.00	14.00	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
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	268,237					11.00
12.00	01200		0				12.00
13.00	01300	16,563	0	1,215,587			13.00
14.00	01400		0	0	0		14.00
16.00	01600	10,320	0	0	0	546,548	16.00
17.00	01700		0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,746	0	239,505	0	20,864	30.00
31.00	03100	2,779	0	15,189	0	1,220	31.00
32.00	03200	0	0	0	0	0	32.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	31,418	0	138,304	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	26,860	0	355,160	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	19,843	0	182,680	0	84,554	50.00
51.00	05100	13,874	0	104,374	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	11,437	0	26,380	0	0	53.00
54.00	05400	25,151	0	212	0	389,520	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	21,096	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	6,425	0	0	0	4,758	65.00
66.00	06600	10,206	0	0	0	6,772	66.00
67.00	06700	3,486	0	0	0	0	67.00
68.00	06800	228	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	2,278	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	10,092	0	0	0	0	73.00
76.97	07697	2,028	0	0	0	16,715	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	27,407	0	153,783	0	22,145	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
118.00		268,237	0	1,215,587	0	546,548	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		268,237	0	1,215,587	0	546,548	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141335

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

Worksheet B
Part I
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,221,870	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	305,494	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,893,104	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	2,250,293	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,121,240	0	50.00
51.00	05100	RECOVERY ROOM	0	912,660	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	446,119	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,571,714	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	1,712,513	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	419,760	0	65.00
66.00	06600	PHYSICAL THERAPY	0	691,409	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	222,196	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,048	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	116,975	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	742,082	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,175,064	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	122,674	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,491,594	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	22,431,809	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	341,752	0	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	22,773,561	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141335

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

Worksheet B
Part II
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,061	0	0	1,061	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,180	133,950	11,365	155,495	5.00
7.00 00700	OPERATION OF PLANT	0	222,185	131,281	353,466	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	12,894	1,274	14,168	8.00
9.00 00900	HOUSEKEEPING	0	5,079	1,182	6,261	9.00
10.00 01000	DIETARY	0	34,370	13,044	47,414	10.00
11.00 01100	CAFETERIA	0	18,476	0	18,476	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	463	6,196	1,377	8,036	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,061	23,792	0	24,853	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,669	93,133	12,832	107,634	30.00
31.00 03100	INTENSIVE CARE UNIT	0	25,648	398	26,046	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	1,062	66,605	6,899	74,566	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	2,727	114,413	17,717	134,857	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	9,816	109,348	174,405	293,569	50.00
51.00 05100	RECOVERY ROOM	643	4,465	2,231	7,339	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	9,486	9,486	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	892	31,886	253,375	286,153	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,061	21,309	16,188	38,558	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	981	18,001	14,910	33,892	65.00
66.00 06600	PHYSICAL THERAPY	463	50,390	2,959	53,812	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	23,250	23,250	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	51,640	7,535	1,600	60,775	73.00
76.97 07697	CARDIAC REHABILITATION	0	6,977	8,112	15,089	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	429	20,276	6,620	27,325	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	84,148	1,026,928	710,505	1,821,581	1,061
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	90,202	0	90,202	192.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	84,148	1,117,130	710,505	1,911,783	1,061

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141335

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	155,707				5.00
7.00	00700	OPERATION OF PLANT	10,760	364,250			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41	6,172	15,905		8.00
9.00	00900	HOUSEKEEPING	2,566	2,431	0	11,276	9.00
10.00	01000	DIETARY	5,312	16,451	0	522	69,739
11.00	01100	CAFETERIA	152	8,843	0	280	15,969
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	8,088	2,966	0	94	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	3,245	11,388	0	361	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,064	44,578	4,677	1,413	5,316
31.00	03100	INTENSIVE CARE UNIT	1,490	12,277	44	389	152
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	9,445	31,880	1,409	1,011	13,431
45.00	04500	NURSING FACILITY	0	0	0	0	0
46.00	04600	OTHER LONG TERM CARE	7,771	54,765	3,617	1,737	34,494
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,394	52,339	3,513	1,659	0
51.00	05100	RECOVERY ROOM	5,347	2,137	374	68	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	2,792	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,170	15,262	904	484	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	11,188	10,199	0	323	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,475	8,616	0	273	0
66.00	06600	PHYSICAL THERAPY	3,713	24,119	498	765	0
67.00	06700	OCCUPATIONAL THERAPY	1,495	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	101	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	784	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,074	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	7,832	3,607	0	114	0
76.97	07697	CARDIAC REHABILITATION	587	3,340	0	106	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	22,081	9,705	814	308	377
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	154,967	321,075	15,850	9,907	69,739
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	740	43,175	55	1,369	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	4,476	0	0
202.00		TOTAL (sum lines 118-201)	155,707	364,250	20,381	11,276	69,739

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141335

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		11.00	12.00	13.00	14.00	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
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	43,720					11.00
12.00	01200	0	0				12.00
13.00	01300	2,700	0	21,960			13.00
14.00	01400	0	0	0	0		14.00
16.00	01600	1,682	0	0	0	41,556	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,359	0	4,327	0	1,586	30.00
31.00	03100	453	0	274	0	93	31.00
32.00	03200	0	0	0	0	0	32.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	5,123	0	2,499	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	4,378	0	6,415	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,234	0	3,300	0	6,429	50.00
51.00	05100	2,261	0	1,886	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	1,864	0	477	0	0	53.00
54.00	05400	4,099	0	4	0	29,616	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	3,438	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,047	0	0	0	362	65.00
66.00	06600	1,664	0	0	1,664	515	66.00
67.00	06700	568	0	0	568	0	67.00
68.00	06800	37	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	371	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	1,645	0	0	0	0	73.00
76.97	07697	330	0	0	0	1,271	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	4,467	0	2,778	0	1,684	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300						113.00
118.00		43,720	0	21,960	0	41,556	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		43,720	0	21,960	0	41,556	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141335

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	185,041	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	41,230	0	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	139,435	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	248,097	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	381,497	0	50.00
51.00	05100	RECOVERY ROOM	0	19,457	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,631	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	350,773	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	63,762	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	46,683	0	65.00
66.00	06600	PHYSICAL THERAPY	0	85,112	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,073	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	139	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,410	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,074	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	74,010	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	20,727	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	69,615	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,771,766	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135,541	0	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	4,476	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,911,783	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141335

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	80,055					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		664,753				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,911,846			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,599	10,633	2,175,788	-3,798,782	18,974,779	5.00
7.00 00700	OPERATION OF PLANT	15,922	122,827	248,267	0	1,311,218	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	924	1,192	0	0	4,982	8.00
9.00 00900	HOUSEKEEPING	364	1,106	185,522	0	312,729	9.00
10.00 01000	DIETARY	2,463	12,204	411,945	0	647,296	10.00
11.00 01100	CAFETERIA	1,324	0	0	0	18,476	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	444	1,288	779,000	0	985,662	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,705	0	279,452	0	395,493	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	6,674	12,006	895,668	0	1,348,268	30.00
31.00 03100	INTENSIVE CARE UNIT	1,838	372	122,723	0	181,613	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
40.00 04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	4,773	6,455	734,408	0	1,150,986	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00 04600	OTHER LONG TERM CARE	8,199	16,576	646,022	0	947,003	46.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	7,836	163,174	620,364	0	2,119,677	50.00
51.00 05100	RECOVERY ROOM	320	2,087	461,132	0	651,634	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	8,875	125,049	0	340,194	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,285	237,060	832,855	0	1,726,774	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	1,527	15,146	578,325	0	1,363,342	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,290	13,950	181,408	0	301,618	65.00
66.00 06600	PHYSICAL THERAPY	3,611	2,768	270,843	0	452,455	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	100,854	0	182,228	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	6,834	0	12,348	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,753	50,530	0	95,565	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	618,298	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	540	1,497	380,018	0	954,403	73.00
76.97 07697	CARDIAC REHABILITATION	500	7,590	44,340	0	71,554	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,453	6,194	780,499	0	2,690,761	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	73,591	664,753	10,911,846	-3,798,782	18,884,577	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	6,464	0	0	0	90,202	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141335

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

Worksheet B-1

Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	1,117,130	710,505	1,795,832	5A	3,798,782	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.954531	1.068826	0.164576		0.200202	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			1,061		155,707	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000097		0.008206	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141335

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

Worksheet B-1

Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	54,534				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	924	172,953			8.00	
9.00	00900	HOUSEKEEPING	364	0	53,246		9.00	
10.00	01000	DIETARY	2,463	0	2,463	55,147	10.00	
11.00	01100	CAFETERIA	1,324	0	1,324	12,628	11,774	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	444	0	444	0	727	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,705	0	1,705	0	453	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,674	50,863	6,674	4,204	1,174	30.00
31.00	03100	INTENSIVE CARE UNIT	1,838	481	1,838	120	122	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,773	15,318	4,773	10,621	1,379	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	8,199	39,336	8,199	27,276	1,179	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,836	38,198	7,836	0	871	50.00
51.00	05100	RECOVERY ROOM	320	4,062	320	0	609	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,285	9,829	2,285	0	1,104	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,527	0	1,527	0	926	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,290	0	1,290	0	282	65.00
66.00	06600	PHYSICAL THERAPY	3,611	5,416	3,611	0	448	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	153	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	10	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	540	0	540	0	443	73.00
76.97	07697	CARDIAC REHABILITATION	500	0	500	0	89	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,453	8,848	1,453	298	1,203	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,070	172,351	46,782	55,147	11,774	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,464	602	6,464	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,573,726	32,644	385,842	865,811	268,237	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.857703	0.188745	7.246403	15.700056	22.782147	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141335

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

Worksheet B-1

Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	364,250	20,381	11,276	69,739	43,720	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.679319	0.091961	0.211772	1.264602	3.713267	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141335

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

Worksheet B-1

Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		MAINTENANCE OF PERSONNEL (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		12.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
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
12.00	01200	0					12.00
13.00	01300	0	109,162				13.00
14.00	01400	0	0	0			14.00
16.00	01600	0	0	0	8,959		16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	21,508	0	342	0	30.00
31.00	03100	0	1,364	0	20	0	31.00
32.00	03200	0	0	0	0	0	32.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	12,420	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
46.00	04600	0	31,894	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	16,405	0	1,386	0	50.00
51.00	05100	0	9,373	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	2,369	0	0	0	53.00
54.00	05400	0	19	0	6,385	0	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	78	0	65.00
66.00	06600	0	0	0	111	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	274	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	13,810	0	363	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
118.00		0	109,162	0	8,959	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		0	1,215,587	0	546,548	0	202.00
203.00		0.000000	11.135624	0.000000	61.005469	0.000000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141335

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

Worksheet B-1

Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		MAINTENANCE OF PERSONNEL (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		12.00	13.00	14.00	16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	21,960	0	41,556	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.201169	0.000000	4.638464	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141335

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,221,870		2,221,870	0	2,221,870 30.00
31.00	03100 INTENSIVE CARE UNIT	305,494		305,494	0	305,494 31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0 32.00
40.00	04000 SUBPROVIDER - I PF	0		0	0	0 40.00
41.00	04100 SUBPROVIDER - I RF	0		0	0	0 41.00
42.00	04200 SUBPROVIDER	0		0	0	0 42.00
43.00	04300 NURSERY	0		0	0	0 43.00
44.00	04400 SKILLED NURSING FACILITY	1,893,104		1,893,104	0	1,893,104 44.00
45.00	04500 NURSING FACILITY	0		0	0	0 45.00
46.00	04600 OTHER LONG TERM CARE	2,250,293		2,250,293	0	2,250,293 46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,121,240		3,121,240	0	3,121,240 50.00
51.00	05100 RECOVERY ROOM	912,660		912,660	0	912,660 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	446,119		446,119	0	446,119 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,571,714		2,571,714	0	2,571,714 54.00
56.00	05600 RADIOISOTOPE	0		0	0	0 56.00
57.00	05700 CT SCAN	0		0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	1,712,513		1,712,513	0	1,712,513 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	419,760	0	419,760	0	419,760 65.00
66.00	06600 PHYSICAL THERAPY	691,409	0	691,409	0	691,409 66.00
67.00	06700 OCCUPATIONAL THERAPY	222,196	0	222,196	0	222,196 67.00
68.00	06800 SPEECH PATHOLOGY	15,048	0	15,048	0	15,048 68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	116,975		116,975	0	116,975 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	742,082		742,082	0	742,082 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,175,064		1,175,064	0	1,175,064 73.00
76.97	07697 CARDIAC REHABILITATION	122,674		122,674	0	122,674 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	3,491,594		3,491,594	0	3,491,594 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	572,364		572,364	0	572,364 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0		0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0		0	0	0 109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0 110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0 111.00
113.00	11300 INTEREST EXPENSE	0		0	0	0 113.00
200.00	Subtotal (see instructions)	23,004,173	0	23,004,173	0	23,004,173 200.00
201.00	Less Observation Beds	572,364		572,364	0	572,364 201.00
202.00	Total (see instructions)	22,431,809	0	22,431,809	0	22,431,809 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141335

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2016 11:44 am

		Title XVIII			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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,472,775		3,472,775		30.00
31.00	03100	INTENSIVE CARE UNIT	222,880		222,880		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
40.00	04000	SUBPROVIDER - I PF	0		0		40.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	918,356		918,356		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
46.00	04600	OTHER LONG TERM CARE	1,066,457		1,066,457		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,396,123	17,657,682	20,053,805	0.155643	50.00
51.00	05100	RECOVERY ROOM	195,612	2,991,735	3,187,347	0.286338	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	99,544	99,544	4.481626	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	870,558	11,282,933	12,153,491	0.211603	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	639,105	4,974,543	5,613,648	0.305062	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	288,848	1,200,381	1,489,229	0.281864	65.00
66.00	06600	PHYSICAL THERAPY	734,108	1,181,474	1,915,582	0.360939	66.00
67.00	06700	OCCUPATIONAL THERAPY	578,551	0	578,551	0.384056	67.00
68.00	06800	SPEECH PATHOLOGY	39,203	0	39,203	0.383848	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,646	0	77,646	1.506517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,169,769	980,814	3,150,583	0.235538	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,520,113	4,401,562	5,921,675	0.198434	73.00
76.97	07697	CARDIAC REHABILITATION	0	203,099	203,099	0.604011	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	201,634	4,192,406	4,394,040	0.794620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,951	678,891	741,842	0.771544	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,454,689	49,845,064	65,299,753		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,454,689	49,845,064	65,299,753		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/29/2016 11:44 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
32.00	03200 CORONARY CARE UNIT			32.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
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
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141335

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2016 11:44 am

		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		2,221,870	0	2,221,870	30.00
31.00	03100 INTENSIVE CARE UNIT		305,494	0	305,494	31.00
32.00	03200 CORONARY CARE UNIT		0	0	0	32.00
40.00	04000 SUBPROVIDER - I/PF		0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		1,893,104	0	1,893,104	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE		2,250,293	0	2,250,293	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		3,121,240	0	3,121,240	50.00
51.00	05100 RECOVERY ROOM		912,660	0	912,660	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		446,119	0	446,119	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,571,714	0	2,571,714	54.00
56.00	05600 RADIOISOTOPE		0	0	0	56.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		1,712,513	0	1,712,513	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	419,760	0	419,760	65.00
66.00	06600 PHYSICAL THERAPY	0	691,409	0	691,409	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	222,196	0	222,196	67.00
68.00	06800 SPEECH PATHOLOGY	0	15,048	0	15,048	68.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		116,975	0	116,975	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		742,082	0	742,082	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,175,064	0	1,175,064	73.00
76.97	07697 CARDIAC REHABILITATION		122,674	0	122,674	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		3,491,594	0	3,491,594	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		572,364	0	572,364	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
200.00	Subtotal (see instructions)		23,004,173	0	23,004,173	200.00
201.00	Less Observation Beds		572,364	0	572,364	201.00
202.00	Total (see instructions)		22,431,809	0	22,431,809	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141335

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2016 11:44 am

		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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,472,775		3,472,775		30.00
31.00	03100	INTENSIVE CARE UNIT	222,880		222,880		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
40.00	04000	SUBPROVIDER - I PF	0		0		40.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	918,356		918,356		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
46.00	04600	OTHER LONG TERM CARE	1,066,457		1,066,457		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,396,123	17,657,682	20,053,805	0.155643	50.00
51.00	05100	RECOVERY ROOM	195,612	2,991,735	3,187,347	0.286338	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	99,544	99,544	4.481626	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	870,558	11,282,933	12,153,491	0.211603	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	639,105	4,974,543	5,613,648	0.305062	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	288,848	1,200,381	1,489,229	0.281864	65.00
66.00	06600	PHYSICAL THERAPY	734,108	1,181,474	1,915,582	0.360939	66.00
67.00	06700	OCCUPATIONAL THERAPY	578,551	0	578,551	0.384056	67.00
68.00	06800	SPEECH PATHOLOGY	39,203	0	39,203	0.383848	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,646	0	77,646	1.506517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,169,769	980,814	3,150,583	0.235538	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,520,113	4,401,562	5,921,675	0.198434	73.00
76.97	07697	CARDIAC REHABILITATION	0	203,099	203,099	0.604011	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	201,634	4,192,406	4,394,040	0.794620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	62,951	678,891	741,842	0.771544	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,454,689	49,845,064	65,299,753		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,454,689	49,845,064	65,299,753		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141335

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

Worksheet C
Part I
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
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
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/29/2016 11:44 am
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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)	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	381,497	20,053,805	0.019024	1,048,989	19,956	50.00
51.00	05100	RECOVERY ROOM	19,457	3,187,347	0.006104	83,739	511	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	14,631	99,544	0.146980	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	350,773	12,153,491	0.028862	282,183	8,144	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	63,762	5,613,648	0.011358	295,802	3,360	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	46,683	1,489,229	0.031347	167,718	5,257	65.00
66.00	06600	PHYSICAL THERAPY	85,112	1,915,582	0.044431	106,157	4,717	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,073	578,551	0.003583	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	139	39,203	0.003546	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,410	77,646	0.314375	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,074	3,150,583	0.001610	902,439	1,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	74,010	5,921,675	0.012498	684,925	8,560	73.00
76.97	07697	CARDIAC REHABILITATION	20,727	203,099	0.102054	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	69,615	4,394,040	0.015843	8,287	131	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	47,668	741,842	0.064256	4,887	314	92.00
200.00		Total (lines 50-199)	1,205,631	59,619,285		3,585,126	52,403	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2016 11:44 am

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)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,053,805	0.000000	0.000000	1,048,989	50.00
51.00	05100	RECOVERY ROOM	0	3,187,347	0.000000	0.000000	83,739	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	99,544	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,153,491	0.000000	0.000000	282,183	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	5,613,648	0.000000	0.000000	295,802	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,489,229	0.000000	0.000000	167,718	65.00
66.00	06600	PHYSICAL THERAPY	0	1,915,582	0.000000	0.000000	106,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	578,551	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	39,203	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77,646	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,150,583	0.000000	0.000000	902,439	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,921,675	0.000000	0.000000	684,925	73.00
76.97	07697	CARDIAC REHABILITATION	0	203,099	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	4,394,040	0.000000	0.000000	8,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	741,842	0.000000	0.000000	4,887	92.00
200.00		Total (lines 50-199)	0	59,619,285			3,585,126	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335

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

Worksheet D
Part IV
Date/Time Prepared:
11/29/2016 11:44 am

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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/29/2016 11:44 am
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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.)			
		1.00	2.00	3.00			
			4.00	5.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.155643	0	4,787,402	0	0	50.00
51.00	05100 RECOVERY ROOM	0.286338	0	774,794	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	4.481626	0	65,917	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211603	0	3,125,784	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.305062	0	1,206,914	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.281864	0	282,830	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.360939	0	348,874	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384056	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.383848	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.506517	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.235538	0	316,726	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.198434	0	1,543,827	9,956	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.604011	0	131,835	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.794620	0	1,107,979	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.771544	0	337,883	0	0	92.00
200.00	Subtotal (see instructions)		0	14,030,765	9,956	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	14,030,765	9,956	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/29/2016 11:44 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	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	745,126	0		50.00
51.00 05100 RECOVERY ROOM	221,853	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	295,415	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	661,425	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	368,184	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	79,720	0		65.00
66.00 06600 PHYSICAL THERAPY	125,922	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	74,601	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	306,348	1,976		73.00
76.97 07697 CARDIAC REHABILITATION	79,630	0		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	880,422	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	260,692	0		92.00
200.00 Subtotal (see instructions)	4,099,338	1,976		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	4,099,338	1,976		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141335 Component CCN: 146014	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/29/2016 11:44 am PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141335 Component CCN: 146014	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/29/2016 11:44 am PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	20,053,805	0.000000	0.000000	0	50.00
51.00 05100 RECOVERY ROOM	0	3,187,347	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	99,544	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	12,153,491	0.000000	0.000000	28,756	54.00
56.00 05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	5,613,648	0.000000	0.000000	13,078	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	1,489,229	0.000000	0.000000	0	65.00
66.00 06600 PHYSICAL THERAPY	0	1,915,582	0.000000	0.000000	408,865	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	578,551	0.000000	0.000000	442,137	67.00
68.00 06800 SPEECH PATHOLOGY	0	39,203	0.000000	0.000000	30,997	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	77,646	0.000000	0.000000	37,936	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	3,150,583	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,921,675	0.000000	0.000000	76,505	73.00
76.97 07697 CARDIAC REHABILITATION	0	203,099	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	4,394,040	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	741,842	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	59,619,285			1,038,274	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141335	Period: From 07/01/2015	Worksheet D Part IV Date/Time Prepared: 11/29/2016 11:44 am
	Component CCN: 146014	To 06/30/2016	
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141335	Period: From 07/01/2015	Worksheet D
		Component CCN: 146014	To 06/30/2016	Part V
		Title XVIII	Skilled Nursing Facility	Date/Time Prepared: 11/29/2016 11:44 am
				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	0.155643	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.286338	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4.481626	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211603	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.305062	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.281864	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.360939	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384056	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.383848	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.506517	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235538	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198434	0	0	3,526	73.00
76.97	07697	CARDIAC REHABILITATION	0.604011	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.794620	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.771544	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	3,526	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	3,526	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141335	Period: From 07/01/2015	Worksheet D Part V Date/Time Prepared: 11/29/2016 11:44 am
	Component CCN: 146014	To 06/30/2016	
	Title XVIII	Skilled Nursing Facility	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	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	700	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	0	700	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	700	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/29/2016 11:44 am
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		Title XIX		Hospital		Cost	
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	0.155643	0	283,095	0	0	50.00
51.00	05100 RECOVERY ROOM	0.286338	0	42,028	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	4.481626	0	1,817	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211603	0	352,990	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.305062	0	133,180	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.281864	0	5,678	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.360939	0	13,503	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384056	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.383848	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.506517	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.235538	0	35,983	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.198434	0	91,169	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0.604011	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.794620	0	242,948	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.771544	0	17,349	0	0	92.00
200.00	Subtotal (see instructions)		0	1,219,740	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	1,219,740	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/29/2016 11:44 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost	
	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	44,062	0	50.00
51.00	05100	RECOVERY ROOM	12,034	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,143	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,694	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	40,628	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,600	0	65.00
66.00	06600	PHYSICAL THERAPY	4,874	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,475	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,091	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	193,051	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,386	0	92.00
200.00		Subtotal (see instructions)	419,038	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	419,038	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 11/29/2016 11:44 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,611	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,611	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)		1,196	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)		666	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,221,870	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,221,870	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,221,870	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)		1,379.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		918,541	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)		918,541	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141335		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Title XVIII		Hospital		Date/Time Prepared: 11/29/2016 11:44 am	
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	305,494	34	8,985.12	18	161,732	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)					781,612	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,861,885	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					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)					415	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,379.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					572,364	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141335		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/29/2016 11:44 am	
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	185,041	2,221,870	0.083282	572,364	47,668	90.00
91.00	Nursing School cost	0	2,221,870	0.000000	572,364	0	91.00
92.00	Allied health cost	0	2,221,870	0.000000	572,364	0	92.00
93.00	All other Medical Education	0	2,221,870	0.000000	572,364	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141335 Component CCN: 146014	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/29/2016 11:44 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,530	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,530	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)		2,530	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)		1,863	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		1,893,104	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)		1,893,104	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,893,104	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141335 Component CCN: 146014		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/29/2016 11:44 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					1,893,104	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					748.26	71.00
72.00	Program routine service cost (line 9 x line 71)					1,394,008	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					1,394,008	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					1,394,008	83.00
84.00	Program inpatient ancillary services (see instructions)					411,685	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					1,805,693	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141335 Component CCN: 146014		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/29/2016 11:44 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/29/2016 11:44 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,823,935		30.00
31.00	03100 INTENSIVE CARE UNIT		111,944		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
40.00	04000 SUBPROVIDER - I/PF		0		40.00
41.00	04100 SUBPROVIDER - I/RF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.155643	1,048,989	163,268	50.00
51.00	05100 RECOVERY ROOM	0.286338	83,739	23,978	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	4.481626	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211603	282,183	59,711	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.305062	295,802	90,238	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.281864	167,718	47,274	65.00
66.00	06600 PHYSICAL THERAPY	0.360939	106,157	38,316	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384056	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.383848	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.506517	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.235538	902,439	212,559	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.198434	684,925	135,912	73.00
76.97	07697 CARDIAC REHABILITATION	0.604011	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.794620	8,287	6,585	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.771544	4,887	3,771	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,585,126	781,612	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		3,585,126		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141335 Component CCN: 146014	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/29/2016 11:44 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
32.00	03200 CORONARY CARE UNIT		0	32.00
40.00	04000 SUBPROVIDER - I PF		0	40.00
41.00	04100 SUBPROVIDER - I RF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.155643	0	50.00
51.00	05100 RECOVERY ROOM	0.286338	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	4.481626	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.211603	28,756	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	56.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.305062	13,078	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.281864	0	65.00
66.00	06600 PHYSICAL THERAPY	0.360939	408,865	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.384056	442,137	67.00
68.00	06800 SPEECH PATHOLOGY	0.383848	30,997	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.506517	37,936	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.235538	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.198434	76,505	73.00
76.97	07697 CARDIAC REHABILITATION	0.604011	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000	0	90.00
91.00	09100 EMERGENCY	0.794620	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.771544	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,038,274	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)		1,038,274	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/29/2016 11:44 am	
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		36,632	30.00
31.00	03100	INTENSIVE CARE UNIT		5,464	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
41.00	04100	SUBPROVIDER - I/RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.155643	13,289	50.00
51.00	05100	RECOVERY ROOM	0.286338	1,703	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	4.481626	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.211603	10,803	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.305062	14,775	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.281864	674	65.00
66.00	06600	PHYSICAL THERAPY	0.360939	3,114	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.384056	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.383848	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.506517	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.235538	83,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.198434	24,151	73.00
76.97	07697	CARDIAC REHABILITATION	0.604011	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.794620	7,234	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.771544	1,740	92.00
200.00		Total (sum of lines 50-94 and 96-98)		161,012	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)		161,012	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/29/2016 11:44 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,101,314 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,101,314 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			4,142,327 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			17,288 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,575,154 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)			1,549,885 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)			1,549,885 30.00
31.00	Primary payer payments			78 31.00
32.00	Subtotal (line 30 minus line 31)			1,549,807 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			1,549,807 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)			1,549,807 40.00
40.01	Sequestration adjustment (see instructions)			30,996 40.01
41.00	Interim payments			1,724,892 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-206,081 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/29/2016 11:44 am
		Component CCN: 146014	Title XVIII	Skilled Nursing Facility
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		700	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		700	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,526	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)		3,526	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)		3,526	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,826	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)		700	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		700	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)		700	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		700	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		700	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		700	40.00
40.01	Sequestration adjustment (see instructions)		14	40.01
41.00	Interim payments		3,456	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-2,770	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141335

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

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2016 11:44 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,788,185		1,724,892		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	02/17/2016	19,721		0		3.50
3.51		05/24/2016	18,281		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)		-38,002		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,750,183		1,724,892		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		79,435		206,081		6.02
7.00	Total Medicare program liability (see instructions)		1,670,748		1,518,811		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141335
Component CCN: 146014

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

Worksheet E-1
Part I
Date/Time Prepared:
11/29/2016 11:44 am
PPS

Title XVIII

Skilled Nursing Facility

		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		714,691		3,456	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		714,691		3,456	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		2,770	6.02
7.00	Total Medicare program liability (see instructions)		714,690		686	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: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/29/2016 11:44 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			408 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			684 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			35 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			1,230 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			65,299,753 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			81,660 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141335	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/29/2016 11:44 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,861,885 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,861,885 4.00
5.00	Primary payer payments			3,081 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,877,423 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,877,423 19.00
20.00	Deductibles (exclude professional component)			172,256 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,705,167 22.00
23.00	Coinsurance			322 23.00
24.00	Subtotal (line 22 minus line 23)			1,704,845 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			0 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,704,845 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			1,704,845 30.00
30.01	Sequestration adjustment (see instructions)			34,097 30.01
31.00	Interim payments			1,750,183 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)			-79,435 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141335 Component CCN: 146014	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 11/29/2016 11:44 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		814,379	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		814,379	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		85,103	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		729,276	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		729,276	15.00
15.01	Sequestration adjustment (see instructions)		14,586	15.01
16.00	Interim payments		714,691	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		-1	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 141335

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

Worksheet G

Date/Time Prepared:
11/29/2016 11:44 am

		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	471,775	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	14,796,403	0	0	0	4.00
5.00	Other receivable	53,265	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,731,629	0	0	0	6.00
7.00	Inventory	809,798	0	0	0	7.00
8.00	Prepaid expenses	280,427	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	159,990	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,840,029	0	0	0	11.00
FIXED ASSETS						
12.00	Land	222,604	0	0	0	12.00
13.00	Land improvements	801,679	0	0	0	13.00
14.00	Accumulated depreciation	-575,417	0	0	0	14.00
15.00	Buildings	20,549,411	0	0	0	15.00
16.00	Accumulated depreciation	-13,368,607	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,671,499	0	0	0	23.00
24.00	Accumulated depreciation	-11,260,133	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,041,036	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,881,065	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	202,245	0	0	0	37.00
38.00	Salaries, wages, and fees payable	743,324	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	-56,365	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	1,585,647	0	0	0	43.00
44.00	Other current liabilities	53,032	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,527,883	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,116,989	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,116,989	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,644,872	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,236,193				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)	5,236,193	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,881,065	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141335

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

Worksheet G-1

Date/Time Prepared:
11/29/2016 11:44 am

		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		1,827,230		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,408,958			2.00
3.00	Total (sum of line 1 and line 2)		5,236,188		0	3.00
4.00	ROUNDING	5		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		5		0	10.00
11.00	Subtotal (line 3 plus line 10)		5,236,193		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		5,236,193		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	ROUNDING		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	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: 141335

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2016 11:44 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,472,775		3,472,775	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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	918,356		918,356	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE	1,066,457		1,066,457	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,457,588		5,457,588	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	222,880		222,880	11.00
12.00	CORONARY CARE UNIT	0		0	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)	222,880		222,880	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,680,468		5,680,468	17.00
18.00	Ancillary services	9,509,636	44,973,767	54,483,403	18.00
19.00	Outpatient services	264,585	4,871,297	5,135,882	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	RECLASS TO IP	-226,039	226,039	0	27.00
27.01	PROFESSIONAL FEES	283	3,474,344	3,474,627	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,228,933	53,545,447	68,774,380	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,861,642		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)		22,861,642		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141335

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

Worksheet G-3

Date/Time Prepared:
11/29/2016 11:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	68,774,380	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,615,667	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,158,713	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,861,642	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,297,071	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	-115	6.00
7.00	Income from investments	1,704	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	106,657	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	3,641	24.00
25.00	Total other income (sum of lines 6-24)	111,887	25.00
26.00	Total (line 5 plus line 25)	3,408,958	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)	3,408,958	29.00