

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/23/2016 11:47 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: 11/23/2016 Time: 11:47 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 ST. JOSEPHS HOSPITAL-HIGHLAND IL (141336) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	100,667	-949,935	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	-318,830	0	0	0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	-218,163	-949,935	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: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 11:57 am
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1515 MAIN STREET	PO Box:		Zip Code: 62249		County: MADISON		1.00		
2.00	City: HIGHLAND	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	
		V			XVIII			XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST. JOSEPHS HOSPITAL-HIGHLAND IL	141336	99914	1	06/01/2004	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. JOSEPHS HOSPITAL-SWING BED	14Z336	99914		08/19/2004	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2015	06/30/2016		20.00	
21.00	Type of Control (see instructions)					1			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 11:57 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.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					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.		N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)		N			60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						0.00	0.00	61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)										
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings										
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))					
			1.00	2.00	3.00					
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.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX					
		1.00		2.00					
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00			
Rural Providers									
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y				105.00			
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00			
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00			
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00			
		Physical		Occupational		Speech		Respiratory	
		1.00		2.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N		N		N	
								1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N			
								1.00	
								1.00	
								2.00	
								3.00	
Miscellaneous Cost Reporting Information									
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N						116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N						117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0						118.00	
		Premiums		Losses		Insurance			
		1.00		2.00		3.00			
118.01	List amounts of malpractice premiums and paid losses:	0		0		0		118.01	
								1.00	
								2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N						118.02	
119.00	DO NOT USE THIS LINE							119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N				120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y						121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.06				122.00	
Transplant Center Information									
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N						125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141336		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 11:57 am		
		1.00	2.00					
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00		
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	148005			140.00		
		1.00	2.00	3.00				
141.00	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						141.00	
	Name: HOSPITAL SISTERS HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131				
142.00	Street: 4936 LAVERNA ROAD	PO Box:				142.00		
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62794				143.00	
						1.00		
144.00	Are provider based physicians' costs included in Worksheet A?						Y	
						1.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N			145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00	
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	
		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	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	157.00		
158.00	SUBPROVIDER					158.00		
159.00	SNF	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC		N	N	N	161.00		
						1.00		
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	
		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	
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)						168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/18/2016 11:57 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2015	06/30/2016 170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N 171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 11:57 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)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	10/24/2016	Y	10/24/2016
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: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/18/2016 11:57 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			Y	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			Y	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.			Y	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.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD LLP		BKD LLP	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502.581.0435		LVCOSTREPORTS@BKD.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.	BKD LLP	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: 141336

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

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2016 11:57 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	45,989.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	45,989.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	45,989.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141336

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

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2016 11:57 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,103	56	3,423			1.00
2.00 HMO and other (see instructions)	459	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	2,512	0	2,926			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	127			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,615	56	6,476			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)	4,615	56	6,476	0.00	198.25	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	198.25	27.00
28.00 Observation Bed Days		21	419			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			66			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: 141336

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

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2016 11:57 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	598	17	1,020	1.00
2.00 HMO and other (see instructions)			117	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	598	17	1,020	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/18/2016 11:57 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)		0.334920	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		764,573	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		3,253,061	6.00	
7.00	Medicaid cost (line 1 times line 6)		1,089,515	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)		324,942	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		324,942	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)	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	604,904	2,089,832	2,694,736	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	202,594	699,927	902,521	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	202,594	699,927	902,521	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?		Y	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)		837,006	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		302,490	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		534,516	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		179,020	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,081,541	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,406,483	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141336

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

Worksheet A
Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,489,343	1,489,343	3,072,233	4,561,576	1.00
2.00	00200		0	0	2,465,398	2,465,398	2.00
4.00	00400	12,156	4,010,103	4,022,259	-1,387	4,020,872	4.00
5.01	01160	0	9,641	9,641	-14,889	-5,248	5.01
5.02	00550	0	1,514,890	1,514,890	-206,304	1,308,586	5.02
5.03	00560	127,819	69,594	197,413	-30,281	167,132	5.03
5.04	00570	355,033	41,186	396,219	-32,188	364,031	5.04
5.05	00580	175,257	656,904	832,161	-5,213	826,948	5.05
5.06	00590	1,466,478	3,499,466	4,965,944	-870,953	4,094,991	5.06
6.00	00600	228,174	45,160	273,334	-9,779	263,555	6.00
7.00	00700	162,648	505,686	668,334	-13,278	655,056	7.00
8.00	00800	0	123,132	123,132	-79	123,053	8.00
9.00	00900	289,326	118,605	407,931	-3,739	404,192	9.00
10.00	01000	400,617	267,141	667,758	-6,404	661,354	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	367,163	9,174	376,337	-1,639	374,698	13.00
16.00	01600	215,607	128,323	343,930	-10,696	333,234	16.00
17.00	01700	178,206	92,256	270,462	-1	270,461	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,905,044	429,255	2,334,299	-288,328	2,045,971	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	997,909	2,106,834	3,104,743	-2,001,155	1,103,588	50.00
53.00	05300	0	825,982	825,982	-33,236	792,746	53.00
54.00	05400	795,765	1,555,309	2,351,074	-982,834	1,368,240	54.00
60.00	06000	641,133	891,414	1,532,547	-527,286	1,005,261	60.00
65.00	06500	305,866	118,311	424,177	-46,095	378,082	65.00
66.00	06600	665,995	37,820	703,815	-26,014	677,801	66.00
67.00	06700	132,318	3,213	135,531	-2,284	133,247	67.00
68.00	06800	17,791	1,828	19,619	-343	19,276	68.00
68.01	03040	84,568	86,884	171,452	-79,863	91,589	68.01
71.00	07100	66,799	81,860	148,659	1,526,733	1,675,392	71.00
72.00	07200	0	0	0	919,064	919,064	72.00
73.00	07300	461,756	790,603	1,252,359	8,478	1,260,837	73.00
76.97	07697	197,588	21,683	219,271	-14,332	204,939	76.97
76.98	07698	195,428	481,942	677,370	-118,089	559,281	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	92,244	9,304	101,548	-8,418	93,130	90.00
91.00	09100	1,086,173	1,439,016	2,525,189	-139,165	2,386,024	91.00
92.00	09200						92.00
93.00	04950	273	433,631	433,904	-3,935	429,969	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		2,227,779	2,227,779	-2,227,779	0	113.00
118.00		11,625,134	24,123,272	35,748,406	285,920	36,034,326	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	53,155	53,155	-1,151	52,004	190.00
192.00	19200	-43	3,142,711	3,142,668	-284,294	2,858,374	192.00
194.00	07950	25,183	5,236	30,419	-475	29,944	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		11,650,274	27,324,374	38,974,648	0	38,974,648	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141336

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

Worksheet A
Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-230,507	4,331,069	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-842,436	1,622,962	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,066,963	2,953,909	4.00
5.01	01160	COMMUNICATIONS	0	-5,248	5.01
5.02	00550	DATA PROCESSING	1,454,220	2,762,806	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	-28	167,104	5.03
5.04	00570	ADMINISTRATIVE	0	364,031	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	826,948	5.05
5.06	00590	OTHER ADMIN & GENERAL	-871,829	3,223,162	5.06
6.00	00600	MAINTENANCE & REPAIRS	-15,412	248,143	6.00
7.00	00700	OPERATION OF PLANT	0	655,056	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-3,784	119,269	8.00
9.00	00900	HOUSEKEEPING	-28,611	375,581	9.00
10.00	01000	DIETARY	-148,142	513,212	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-250	374,448	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,526	327,708	16.00
17.00	01700	SOCIAL SERVICE	0	270,461	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,045,971	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,037	1,102,551	50.00
53.00	05300	ANESTHESIOLOGY	-708,193	84,553	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-31	1,368,209	54.00
60.00	06000	LABORATORY	-24,882	980,379	60.00
65.00	06500	RESPIRATORY THERAPY	-32,550	345,532	65.00
66.00	06600	PHYSICAL THERAPY	-307	677,494	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	133,247	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,276	68.00
68.01	03040	AUDIOLOGY	-52	91,537	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-490	1,674,902	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	919,064	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,260,837	73.00
76.97	07697	CARDIAC REHABILITATION	-4,288	200,651	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-25,962	533,319	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	93,130	90.00
91.00	09100	EMERGENCY	0	2,386,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	-273	429,696	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,557,333	33,476,993	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	52,004	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	-2,847,506	10,868	192.00
194.00	07950	TRANSPORTATION	0	29,944	194.00
194.01	07951	FUND DEVELOPMENT	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-5,404,839	33,569,809	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	811,880	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	388,981	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
TOTALS			0	1,200,861	
B - TELEPHONE					
1.00	COMMUNICATIONS	5.01	0	542	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS			0	542	
C - POSTAGE					
1.00	OTHER ADMIN & GENERAL	5.06	0	14,037	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
TOTALS			0	14,037	
D - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,227,779	1.00
TOTALS			0	2,227,779	
E - MED SUPPLIES - IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	1,590,709	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	919,064	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,484	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
TOTALS					
			0	2,515,257	
F - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	49,584	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
TOTALS					
			0	49,584	
G - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	32,574	1.00
TOTALS					
			0	32,574	
H - SHARED DIRECTORS					
1.00	MAINTENANCE & REPAIRS	6.00	1,626	0	1.00
2.00	OPERATION OF PLANT	7.00	1,626	0	2.00
3.00	HOUSEKEEPING	9.00	3,253	0	3.00
TOTALS					
			6,505	0	
I - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,076,417	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
TOTALS					
			0	2,076,417	
J - NEGATIVE SALARIES					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	43	0	1.00
TOTALS					
			43	0	
500.00	Grand Total: Increases		6,548	8,117,051	500.00

RECLASSIFICATIONS

Provider CCN: 141336

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

Worksheet A-6
Date/Time Prepared:
11/18/2016 11:57 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - RENTAL						
1.00	DATA PROCESSING	5.02	0	3,099	10	1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	0	12,060	10	2.00
3.00	ADMINISTRATING	5.04	0	3,388	0	3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	3,197	0	4.00
5.00	OTHER ADMIN & GENERAL	5.06	0	820,092	0	5.00
6.00	MAINTENANCE & REPAIRS	6.00	0	4,260	0	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,727	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	36,704	0	8.00
9.00	OPERATING ROOM	50.00	0	247,080	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	606	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,449	0	11.00
12.00	LABORATORY	60.00	0	6,019	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	2,556	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	3,906	0	14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	128	0	15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	36,431	0	16.00
17.00	CARDIAC REHABILITATION	76.97	0	954	0	17.00
18.00	HYPERBARIC OXYGEN THERAPY	76.98	0	1,478	0	18.00
19.00	EMERGENCY	91.00	0	4,221	0	19.00
20.00	O/P GERIATRIC PSYCH CENTER	93.00	0	2,291	0	20.00
21.00	PHYSICIANS PRIVATE OFFICES	192.00	0	4,215	0	21.00
	TOTALS		0	1,200,861		
B - TELEPHONE						
1.00	PURCHASING RECEIVING AND STORES	5.03	0	21	0	1.00
2.00	OPERATION OF PLANT	7.00	0	46	0	2.00
3.00	TRANSPORTATION	194.00	0	475	0	3.00
	TOTALS		0	542		
C - POSTAGE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	151	0	1.00
2.00	DATA PROCESSING	5.02	0	186	0	2.00
3.00	PURCHASING RECEIVING AND STORES	5.03	0	11,715	0	3.00
4.00	MAINTENANCE & REPAIRS	6.00	0	9	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	262	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	289	0	6.00
7.00	OPERATING ROOM	50.00	0	350	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	153	0	8.00
9.00	LABORATORY	60.00	0	165	0	9.00
10.00	RESPIRATORY THERAPY	65.00	0	135	0	10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	19	0	11.00
12.00	AUDIOLOGY	68.01	0	52	0	12.00
13.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	158	0	13.00
14.00	HYPERBARIC OXYGEN THERAPY	76.98	0	20	0	14.00
15.00	EMERGENCY	91.00	0	182	0	15.00
16.00	O/P GERIATRIC PSYCH CENTER	93.00	0	3	0	16.00
17.00	GI FT FLOWER COFFEE SHOP & CAN	190.00	0	188	0	17.00
	TOTALS		0	14,037		
D - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	2,227,779	11	1.00
	TOTALS		0	2,227,779		
E - MED SUPPLIES - IMPLANTS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1	0	1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	0	2,818	0	2.00
3.00	ADMINISTRATING	5.04	0	2,477	0	3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	2	0	4.00
5.00	OTHER ADMIN & GENERAL	5.06	0	1,919	0	5.00
6.00	MAINTENANCE & REPAIRS	6.00	0	4,147	0	6.00
7.00	OPERATION OF PLANT	7.00	0	2,269	0	7.00
8.00	LAUNDRY & LINEN SERVICE	8.00	0	79	0	8.00
9.00	HOUSEKEEPING	9.00	0	2,524	0	9.00
10.00	DIETARY	10.00	0	260	0	10.00
11.00	NURSING ADMINISTRATION	13.00	0	701	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	11	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	0	133,887	0	13.00
14.00	OPERATING ROOM	50.00	0	1,475,981	0	14.00
15.00	ANESTHESIOLOGY	53.00	0	22,041	0	15.00

RECLASSIFICATIONS

Provider CCN: 141336

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

Worksheet A-6
Date/Time Prepared:
11/18/2016 11:57 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	100,647	0	16.00	
17.00	LABORATORY	60.00	0	457,826	0	17.00	
18.00	RESPIRATORY THERAPY	65.00	0	30,374	0	18.00	
19.00	PHYSICAL THERAPY	66.00	0	9,920	0	19.00	
20.00	OCCUPATIONAL THERAPY	67.00	0	2,137	0	20.00	
21.00	AUDIOLOGY	68.01	0	78,095	0	21.00	
22.00	CARDIAC REHABILITATION	76.97	0	3,939	0	22.00	
23.00	HYPERBARIC OXYGEN THERAPY	76.98	0	98,006	0	23.00	
24.00	CLINIC	90.00	0	8,418	0	24.00	
25.00	EMERGENCY	91.00	0	76,450	0	25.00	
26.00	O/P GERIATRIC PSYCH CENTER	93.00	0	212	0	26.00	
27.00	GIFT FLOWER COFFEE SHOP & CAN	190.00	0	116	0	27.00	
	TOTALS		0	2,515,257			
F - DRUGS CHARGED TO PATIENTS							
1.00	PURCHASING RECEIVING AND STORES	5.03	0	659	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	9,291	0	2.00	
3.00	OPERATING ROOM	50.00	0	13,432	0	3.00	
4.00	ANESTHESIOLOGY	53.00	0	84	0	4.00	
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,483	0	5.00	
6.00	LABORATORY	60.00	0	253	0	6.00	
7.00	HYPERBARIC OXYGEN THERAPY	76.98	0	4,267	0	7.00	
8.00	EMERGENCY	91.00	0	10,115	0	8.00	
	TOTALS		0	49,584			
G - PROPERTY INSURANCE							
1.00	OTHER ADMIN & GENERAL	5.06	0	32,574	12	1.00	
	TOTALS		0	32,574			
H - SHARED DIRECTORS							
1.00	OTHER ADMIN & GENERAL	5.06	6,505	0	0	1.00	
2.00		0.00	0	0	0	2.00	
3.00		0.00	0	0	0	3.00	
	TOTALS		6,505	0			
I - DEPRECIATION							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,235	9	1.00	
2.00	COMMUNICATIONS	5.01	0	15,431	0	2.00	
3.00	DATA PROCESSING	5.02	0	203,019	0	3.00	
4.00	PURCHASING RECEIVING AND STORES	5.03	0	3,008	0	4.00	
5.00	ADMINISTRATIVE	5.04	0	26,323	0	5.00	
6.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	2,014	0	6.00	
7.00	OTHER ADMIN & GENERAL	5.06	0	23,900	0	7.00	
8.00	MAINTENANCE & REPAIRS	6.00	0	2,989	0	8.00	
9.00	OPERATION OF PLANT	7.00	0	12,589	0	9.00	
10.00	HOUSEKEEPING	9.00	0	4,468	0	10.00	
11.00	DIETARY	10.00	0	6,144	0	11.00	
12.00	NURSING ADMINISTRATION	13.00	0	938	0	12.00	
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,696	0	13.00	
14.00	SOCIAL SERVICE	17.00	0	1	0	14.00	
15.00	ADULTS & PEDIATRICS	30.00	0	108,157	0	15.00	
16.00	OPERATING ROOM	50.00	0	264,312	0	16.00	
17.00	ANESTHESIOLOGY	53.00	0	10,505	0	17.00	
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	869,102	0	18.00	
19.00	LABORATORY	60.00	0	63,023	0	19.00	
20.00	RESPIRATORY THERAPY	65.00	0	13,030	0	20.00	
21.00	PHYSICAL THERAPY	66.00	0	12,188	0	21.00	
22.00	SPEECH PATHOLOGY	68.00	0	343	0	22.00	
23.00	AUDIOLOGY	68.01	0	1,716	0	23.00	
24.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	63,818	0	24.00	
25.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,159	0	25.00	
26.00	CARDIAC REHABILITATION	76.97	0	9,439	0	26.00	
27.00	HYPERBARIC OXYGEN THERAPY	76.98	0	14,318	0	27.00	
28.00	EMERGENCY	91.00	0	48,197	0	28.00	
29.00	O/P GERIATRIC PSYCH CENTER	93.00	0	1,429	0	29.00	
30.00	GIFT FLOWER COFFEE SHOP & CAN	190.00	0	847	0	30.00	
31.00	PHYSICIANS PRIVATE OFFICES	192.00	0	280,079	0	31.00	
	TOTALS		0	2,076,417			
J - NEGATIVE SALARIES							
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	43	0	1.00	
	TOTALS		0	43			
500.00	Grand Total: Decreases		6,505	8,117,094		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141336

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

Worksheet A-7
Part I
Date/Time Prepared:
11/18/2016 11:57 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,759,039	0	0	274,151	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	35,581,986	0	0	1,916,475	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	10,870,660	0	0	3,231,434	6.00
7.00	HIT designated Assets	10,000,000	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,211,685	0	0	5,422,060	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	60,211,685	0	0	5,422,060	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,484,888	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	33,665,511	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	7,639,226	0			6.00
7.00	HIT designated Assets	10,000,000	0			7.00
8.00	Subtotal (sum of lines 1-7)	54,789,625	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	54,789,625	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141336

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

Worksheet A-7
Part II
Date/Time Prepared:
11/18/2016 11:57 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	CAP REL COSTS-BLDG & FIXT	1,489,343	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,489,343	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,489,343				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,489,343				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141336

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

Worksheet A-7
Part III
Date/Time Prepared:
11/18/2016 11:57 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	CAP REL COSTS-BLDG & FIXT	47,150,399	0	47,150,399	0.860572	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,639,226	0	7,639,226	0.139428	0	2.00
3.00	Total (sum of lines 1-2)	54,789,625	0	54,789,625	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,489,343	581,373	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,233,981	388,981	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,723,324	970,354	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,227,779	32,574	0	0	4,331,069	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,622,962	2.00
3.00	Total (sum of lines 1-2)	2,227,779	32,574	0	0	5,954,031	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-29,810	CAP REL COSTS-BLDG & FIXT	1.00	10	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-63,837			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,197,621			0	12.00
13.00 Laundry and linen service	B	-3,784	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00 Cafeteria-employees and guests	B	-148,142	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-490	MEDICAL SUPPLIES CHARGED TO PAT	71.00	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	-5,168	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-954,192	CAP REL COSTS-MVBLE EQUIP	2.00		9 32.00
33.00 MISCELLANEOUS INCOME	B	-300	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.00
33.01 MISCELLANEOUS INCOME	B	4,985	DATA PROCESSING	5.02		0 33.01
33.02 MISCELLANEOUS INCOME	B	-28	PURCHASING RECEIVING AND STORES	5.03		0 33.02
33.03 MISCELLANEOUS INCOME	B	-47,720	OTHER ADMIN & GENERAL	5.06		0 33.03
33.04 MISCELLANEOUS INCOME	B	-15,412	MAINTENANCE & REPAIRS	6.00		0 33.04
33.05 MISCELLANEOUS INCOME	B	-28,611	HOUSEKEEPING	9.00		0 33.05
33.06 MISCELLANEOUS INCOME	B	-250	NURSING ADMINISTRATION	13.00		0 33.06
33.07 MISCELLANEOUS INCOME	B	-31	RADIOLOGY-DIAGNOSTIC	54.00		0 33.07
33.08 MISCELLANEOUS INCOME	B	-24,882	LABORATORY	60.00		0 33.08
33.09 MISCELLANEOUS INCOME	B	-307	PHYSICAL THERAPY	66.00		0 33.09
33.10 MISCELLANEOUS INCOME	B	-52	AUDIOLOGY	68.01		0 33.10
33.11 MISCELLANEOUS INCOME	B	-273	O/P GERIATRIC PSYCH CENTER	93.00		0 33.11
33.12 ADVERTISING	A	-599	OTHER ADMIN & GENERAL	5.06		0 33.12
33.13 MEDI CAID TAX ASSESSMENT	A	-503,203	OTHER ADMIN & GENERAL	5.06		0 33.13
33.14 CRNA	A	-708,193	ANESTHESIOLOGY	53.00		0 33.14
33.15 PENSION ADJUSTMENT	A	-266,110	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.15
33.16 HSHS MED GROUP ADMIN	A	-2,847,506	PHYSICIANS PRIVATE OFFICES	192.00		0 33.16
33.17 USEFULL LIVES CARRYFORWARD ADJUSTMEN	A	111,756	CAP REL COSTS-MVBLE EQUIP	2.00		9 33.17
33.18 LOBBYING EXPENSE	A	-13,247	OTHER ADMIN & GENERAL	5.06		0 33.18
33.19 COMMUNITY RELATIONS BENEFITS	A	-21,650	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.19
33.20 COMMUNITY RELATIONS SALARY	A	-78,564	OTHER ADMIN & GENERAL	5.06		0 33.20
33.21 COMMUNITY RELATIONS OTHER EXPENSE	A	-177,937	OTHER ADMIN & GENERAL	5.06		0 33.21
33.22 SELF-INSURANCE ADJUSTMENT	A	-778,903	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.22
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,404,839				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: 141336
 Period: From 07/01/2015 To 06/30/2016
 Worksheet A-8-1
 Date/Time Prepared: 11/18/2016 11:57 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	5.02	DATA PROCESSING	INFORMATION SYSTEMS --ISC MA	2,742,622	1,293,387
2.00	5.06	OTHER ADMIN & GENERAL	ADMINISTRATION --ISC MANAGEM	0	253
3.00	16.00	MEDICAL RECORDS & LIBRARY	HEALTH INFORMATION SERVICES	0	358
4.00	5.06	OTHER ADMIN & GENERAL	QUALITY ASSURANCE --ISC MANA	0	45,370
4.01	5.06	OTHER ADMIN & GENERAL	ADMINISTRATION --SSC MANAGEM	772,523	761,025
4.02	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST --INTEREST EXPENSE-	0	200,697
4.03	5.06	OTHER ADMIN & GENERAL	ADMINISTRATION --PURCHASED S	0	16,434
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,515,145	2,317,524

* 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	HSHS	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 141336

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

Worksheet A-8-1

Date/Time Prepared:
11/18/2016 11:57 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	1,449,235	0		1.00
2.00	-253	0		2.00
3.00	-358	0		3.00
4.00	-45,370	0		4.00
4.01	11,498	0		4.01
4.02	-200,697	10		4.02
4.03	-16,434	0		4.03
5.00	1,197,621			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141336

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

Worksheet A-8-2

Date/Time Prepared:
11/18/2016 11:57 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	OPERATING ROOM	1,037	1,037	0	0	0	1.00
2.00	60.00	LABORATORY	92,426	0	92,426	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	32,550	32,550	0	0	0	3.00
4.00	76.97	CARDIAC REHABILITATION	4,288	4,288	0	0	0	4.00
5.00	76.98	HYPERBARIC OXYGEN THERAPY	25,962	25,962	0	0	0	5.00
6.00	91.00	EMERGENCY	1,140,565	0	1,140,565	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,296,828	63,837	1,232,991			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	OPERATING ROOM	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	4.00
5.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	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	OPERATING ROOM	0	0	0	1,037		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	32,550		3.00
4.00	76.97	CARDIAC REHABILITATION	0	0	0	4,288		4.00
5.00	76.98	HYPERBARIC OXYGEN THERAPY	0	0	0	25,962		5.00
6.00	91.00	EMERGENCY	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	63,837		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141336

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,331,069	4,331,069			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,622,962		1,622,962		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,953,909	0	965	2,954,874	4.00
5.01 01160	COMMUNICATIONS	-5,248	0	12,061	0	6,813 5.01
5.02 00550	DATA PROCESSING	2,762,806	70,653	158,683	0	1,147 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	167,104	0	2,351	32,453	114 5.03
5.04 00570	ADMINISTRATIVE	364,031	40,724	20,575	90,141	123 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	826,948	0	1,574	44,497	184 5.05
5.06 00590	OTHER ADMIN & GENERAL	3,223,162	504,920	18,681	370,680	648 5.06
6.00 00600	MAINTENANCE & REPAIRS	248,143	0	2,336	58,345	114 6.00
7.00 00700	OPERATION OF PLANT	655,056	227,080	9,840	41,708	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	119,269	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	375,581	91,617	3,492	74,284	44 9.00
10.00 01000	DIETARY	513,212	117,487	4,802	101,715	114 10.00
11.00 01100	CAFETERIA	0	108,210	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	374,448	0	733	93,221	0 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	327,708	53,882	2,889	54,742	289 16.00
17.00 01700	SOCIAL SERVICE	270,461	0	1	45,246	18 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,045,971	785,302	84,537	483,683	779 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,102,551	664,647	206,591	253,364	263 50.00
53.00 05300	ANESTHESIOLOGY	84,553	0	8,211	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,368,209	364,416	679,305	202,041	193 54.00
60.00 06000	LABORATORY	980,379	140,191	49,260	162,780	210 60.00
65.00 06500	RESPIRATORY THERAPY	345,532	92,821	10,184	77,658	193 65.00
66.00 06600	PHYSICAL THERAPY	677,494	248,892	9,526	169,093	333 66.00
67.00 06700	OCCUPATIONAL THERAPY	133,247	0	0	33,595	0 67.00
68.00 06800	SPEECH PATHOLOGY	19,276	0	268	4,517	0 68.00
68.01 03040	AUDIOLOGY	91,537	25,157	1,341	21,471	0 68.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	1,674,902	207,945	49,881	16,960	105 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	919,064	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,260,837	52,588	7,940	117,238	114 73.00
76.97 07697	CARDIAC REHABILITATION	200,651	67,263	7,378	50,167	201 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	533,319	0	11,191	49,618	140 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	93,130	0	0	23,420	0 90.00
91.00 09100	EMERGENCY	2,386,024	321,909	37,672	275,774	254 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0 92.00
93.00 04950	O/P GERIATRIC PSYCH CENTER	429,696	110,529	1,117	69	0 93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,476,993	4,296,233	1,403,385	2,948,480	5,580 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	52,004	34,836	662	0	0 190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	10,868	0	218,915	0	1,233 192.00
194.00 07950	TRANSPORTATION	29,944	0	0	6,394	0 194.00
194.01 07951	FUND DEVELOPMENT	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	33,569,809	4,331,069	1,622,962	2,954,874	6,813 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141336

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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00550	DATA PROCESSING	2,993,289					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	201,480	403,502				5.03
5.04	00570	ADMINISTRATIVE	383,406	948	899,948			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	25	0	873,228		5.05
5.06	00590	OTHER ADMIN & GENERAL	1,637,340	5,285	0	0	5,760,716	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	677	0	0	309,615	6.00
7.00	00700	OPERATION OF PLANT	0	226	0	0	933,910	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	105	0	0	119,374	8.00
9.00	00900	HOUSEKEEPING	0	319	0	0	545,337	9.00
10.00	01000	DIETARY	66,310	315	0	0	803,955	10.00
11.00	01100	CAFETERIA	0	0	0	0	108,210	11.00
13.00	01300	NURSING ADMINISTRATION	0	222	0	0	468,624	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	145,371	227	0	0	585,108	16.00
17.00	01700	SOCIAL SERVICE	0	144	0	0	315,870	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	222,733	829	124,359	42,608	3,790,801	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	71,410	2,511	52,146	72,297	2,425,780	50.00
53.00	05300	ANESTHESIOLOGY	0	32	33,110	28,790	154,696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	904	223,657	266,546	3,105,271	54.00
60.00	06000	LABORATORY	147,072	450	141,057	173,317	1,794,716	60.00
65.00	06500	RESPIRATORY THERAPY	0	640	28,870	19,254	575,152	65.00
66.00	06600	PHYSICAL THERAPY	0	445	29,993	32,441	1,168,217	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3	11,896	4,865	183,606	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,145	719	25,925	68.00
68.01	03040	AUDIOLOGY	0	251	0	2,315	142,072	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	242,685	65,581	34,754	2,292,813	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	138,737	34,576	16,138	1,108,515	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	335	122,767	71,088	1,632,907	73.00
76.97	07697	CARDIAC REHABILITATION	0	240	0	5,924	331,824	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	555	0	21,393	616,216	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	134	0	3,421	120,105	90.00
91.00	09100	EMERGENCY	118,167	542	30,791	72,307	3,243,440	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	102	0	5,051	546,564	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,993,289	397,888	899,948	873,228	33,209,339	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	5,590	0	0	93,092	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6	0	0	231,022	192.00
194.00	07950	TRANSPORTATION	0	18	0	0	36,356	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,993,289	403,502	899,948	873,228	33,569,809	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590	5,760,716					5.06
6.00	00600	64,137	373,752				6.00
7.00	00700	193,461	0	1,127,371			7.00
8.00	00800	24,729	15,764	0	159,867		8.00
9.00	00900	112,968	36,934	29,615	0	724,854	9.00
10.00	01000	166,541	16,395	37,977	2,161	48	10.00
11.00	01100	22,416	180	34,978	0	17,185	11.00
13.00	01300	97,076	15,855	0	0	952	13.00
16.00	01600	121,206	10,089	17,417	0	1,428	16.00
17.00	01700	65,433	0	0	0	48	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	785,281	76,930	253,842	72,235	288,665	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	502,505	20,719	214,842	22,061	51,459	50.00
53.00	05300	32,046	0	0	0	0	53.00
54.00	05400	643,263	10,540	117,795	14,517	42,652	54.00
60.00	06000	371,779	8,558	45,316	0	24,563	60.00
65.00	06500	119,144	2,252	30,004	2,836	7,902	65.00
66.00	06600	241,998	5,315	80,452	11,043	33,322	66.00
67.00	06700	38,034	0	0	0	0	67.00
68.00	06800	5,370	0	0	0	0	68.00
68.01	03040	29,430	180	8,132	0	3,332	68.01
71.00	07100	474,961	2,432	67,217	574	6,760	71.00
72.00	07200	229,631	0	0	0	0	72.00
73.00	07300	338,260	3,964	16,999	0	3,237	73.00
76.97	07697	68,738	5,405	21,742	0	10,949	76.97
76.98	07698	127,650	5,225	0	4,235	23,326	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	24,880	90	0	0	21,469	90.00
91.00	09100	671,885	74,408	104,055	29,019	89,970	91.00
92.00	09200						92.00
93.00	04950	113,222	0	35,728	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		5,686,044	311,235	1,116,111	158,681	627,267	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	19,284	7,026	11,260	0	286	190.00
192.00	19200	47,857	52,698	0	1,186	97,301	192.00
194.00	07950	7,531	2,793	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		5,760,716	373,752	1,127,371	159,867	724,854	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,027,077					10.00
11.00	01100	516,418	699,387				11.00
13.00	01300	0	17,062	599,569			13.00
16.00	01600	0	31,338	0	766,586		16.00
17.00	01700	0	11,391	0	0	392,742	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	279,204	194,547	313,868	453,152	387,925	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	80,733	137,666	67,244	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	55,414	0	62,014	0	54.00
60.00	06000	0	63,223	0	16,438	0	60.00
65.00	06500	0	27,806	0	0	0	65.00
66.00	06600	30,607	51,534	0	76,584	0	66.00
67.00	06700	0	8,954	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
68.01	03040	0	4,228	0	0	0	68.01
71.00	07100	0	8,705	32	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	18,703	0	0	0	73.00
76.97	07697	0	13,082	21,232	7,472	0	76.97
76.98	07698	0	17,559	0	4,483	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	11,540	0	0	0	90.00
91.00	09100	14,395	77,947	126,771	56,037	1,297	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		840,624	693,766	599,569	743,424	389,222	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	995	0	23,162	3,520	192.00
194.00	07950	186,453	4,626	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,027,077	699,387	599,569	766,586	392,742	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	01160					5.01
5.02	00550					5.02
5.03	00560					5.03
5.04	00570					5.04
5.05	00580					5.05
5.06	00590					5.06
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
16.00	01600					16.00
17.00	01700					17.00
19.00	01900	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	6,896,450	0	6,896,450	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	3,523,009	0	3,523,009	50.00
53.00	05300	0	186,742	0	186,742	53.00
54.00	05400	0	4,051,466	0	4,051,466	54.00
60.00	06000	0	2,324,593	0	2,324,593	60.00
65.00	06500	0	765,096	0	765,096	65.00
66.00	06600	0	1,699,072	0	1,699,072	66.00
67.00	06700	0	230,594	0	230,594	67.00
68.00	06800	0	31,295	0	31,295	68.00
68.01	03040	0	187,374	0	187,374	68.01
71.00	07100	0	2,853,494	0	2,853,494	71.00
72.00	07200	0	1,338,146	0	1,338,146	72.00
73.00	07300	0	2,014,070	0	2,014,070	73.00
76.97	07697	0	480,444	0	480,444	76.97
76.98	07698	0	798,694	0	798,694	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	178,084	0	178,084	90.00
91.00	09100	0	4,489,224	0	4,489,224	91.00
92.00	09200	0		0		92.00
93.00	04950	0	695,514	0	695,514	93.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	0				113.00
118.00		0	32,743,361	0	32,743,361	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	130,948	0	130,948	190.00
192.00	19200	0	457,741	0	457,741	192.00
194.00	07950	0	237,759	0	237,759	194.00
194.01	07951	0	0	0	0	194.01
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		0	33,569,809	0	33,569,809	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141336

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

Worksheet B
Part II
Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	965	4.00
5.01	01160	COMMUNICATIONS	0	0	12,061	5.01
5.02	00550	DATA PROCESSING	0	70,653	158,683	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	2,351	5.03
5.04	00570	ADMINISTRATIVE	0	40,724	20,575	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	1,574	5.05
5.06	00590	OTHER ADMIN & GENERAL	0	504,920	18,681	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,336	6.00
7.00	00700	OPERATION OF PLANT	0	227,080	9,840	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	91,617	3,492	9.00
10.00	01000	DIETARY	0	117,487	4,802	10.00
11.00	01100	CAFETERIA	0	108,210	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	733	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53,882	2,889	16.00
17.00	01700	SOCIAL SERVICE	0	0	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	785,302	84,537	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	664,647	206,591	50.00
53.00	05300	ANESTHESIOLOGY	0	0	8,211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	364,416	679,305	54.00
60.00	06000	LABORATORY	0	140,191	49,260	60.00
65.00	06500	RESPIRATORY THERAPY	0	92,821	10,184	65.00
66.00	06600	PHYSICAL THERAPY	0	248,892	9,526	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	268	68.00
68.01	03040	AUDIOLOGY	0	25,157	1,341	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	207,945	49,881	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	52,588	7,940	73.00
76.97	07697	CARDIAC REHABILITATION	0	67,263	7,378	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	11,191	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	321,909	37,672	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	110,529	1,117	93.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,296,233	1,403,385	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	34,836	662	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	218,915	192.00
194.00	07950	TRANSPORTATION	0	0	0	194.00
194.01	07951	FUND DEVELOPMENT	0	0	0	194.01
200.00		Cross Foot Adjustments			0	200.00
201.00		Negative Cost Centers		0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	4,331,069	1,622,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141336		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/18/2016 11:57 am	
Cost Center Description		COMMUNICATIONS	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/AC COUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160	6,813					5.01
5.02	00550	1,147	230,483				5.02
5.03	00560	114	15,514	17,990			5.03
5.04	00570	123	29,522	42	91,015		5.04
5.05	00580	184	0	1	0	1,774	5.05
5.06	00590	648	126,075	236	0	0	5.06
6.00	00600	114	0	30	0	0	6.00
7.00	00700	0	0	10	0	0	7.00
8.00	00800	0	0	5	0	0	8.00
9.00	00900	44	0	14	0	0	9.00
10.00	01000	114	5,106	14	0	0	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	0	0	10	0	0	13.00
16.00	01600	289	11,194	10	0	0	16.00
17.00	01700	18	0	6	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	779	17,150	37	12,576	86	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	263	5,499	112	5,273	146	50.00
53.00	05300	0	0	1	3,348	58	53.00
54.00	05400	193	0	40	22,624	551	54.00
60.00	06000	210	11,324	20	14,264	349	60.00
65.00	06500	193	0	29	2,920	39	65.00
66.00	06600	333	0	20	3,033	65	66.00
67.00	06700	0	0	0	1,203	10	67.00
68.00	06800	0	0	0	116	1	68.00
68.01	03040	0	0	11	0	5	68.01
71.00	07100	105	0	10,821	6,632	70	71.00
72.00	07200	0	0	6,185	3,497	33	72.00
73.00	07300	114	0	15	12,415	143	73.00
76.97	07697	201	0	11	0	12	76.97
76.98	07698	140	0	25	0	43	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	6	0	7	90.00
91.00	09100	254	9,099	24	3,114	146	91.00
92.00	09200						92.00
93.00	04950	0	0	5	0	10	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		5,580	230,483	17,740	91,015	1,774	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	249	0	0	190.00
192.00	19200	1,233	0	0	0	0	192.00
194.00	07950	0	0	1	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		5,248	0	0	0	0	201.00
202.00		12,061	230,483	17,990	91,015	1,774	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/18/2016 11:57 am		
Cost Center Description		OTHER ADMIN & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
		5.06	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	01160					5.01
5.02	00550					5.02
5.03	00560					5.03
5.04	00570					5.04
5.05	00580					5.05
5.06	00590	650,681				5.06
6.00	00600	7,244	9,743			6.00
7.00	00700	21,852	0	258,796		7.00
8.00	00800	2,793	411	0	3,209	8.00
9.00	00900	12,760	963	6,798	0	115,712
10.00	01000	18,811	427	8,718	43	8
11.00	01100	2,532	5	8,029	0	2,743
13.00	01300	10,965	413	0	0	152
16.00	01600	13,690	263	3,998	0	228
17.00	01700	7,391	0	0	0	8
19.00	01900	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	88,701	2,005	58,271	1,450	46,080
ANCILLARY SERVICE COST CENTERS						
50.00	05000	56,758	540	49,319	443	8,215
53.00	05300	3,620	0	0	0	0
54.00	05400	72,657	275	27,041	291	6,809
60.00	06000	41,993	223	10,403	0	3,921
65.00	06500	13,457	59	6,888	57	1,261
66.00	06600	27,334	139	18,468	222	5,319
67.00	06700	4,296	0	0	0	0
68.00	06800	607	0	0	0	0
68.01	03040	3,324	5	1,867	0	532
71.00	07100	53,647	63	15,430	12	1,079
72.00	07200	25,937	0	0	0	0
73.00	07300	38,207	103	3,902	0	517
76.97	07697	7,764	141	4,991	0	1,748
76.98	07698	14,418	136	0	85	3,724
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	2,810	2	0	0	3,427
91.00	09100	75,890	1,940	23,886	582	14,362
92.00	09200					
93.00	04950	12,789	0	8,202	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300					
118.00		642,247	8,113	256,211	3,185	100,133
NONREIMBURSABLE COST CENTERS						
190.00	19000	2,178	183	2,585	0	46
192.00	19200	5,405	1,374	0	24	15,533
194.00	07950	851	73	0	0	0
194.01	07951	0	0	0	0	0
200.00						
201.00		0	0	0	0	0
202.00		650,681	9,743	258,796	3,209	115,712

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141336

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

Worksheet B
Part II
Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	155,563					10.00
11.00	01100	78,217	199,736				11.00
13.00	01300	0	4,873	17,176			13.00
16.00	01600	0	8,950	0	95,411		16.00
17.00	01700	0	3,253	0	0	10,692	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	42,289	55,560	8,991	56,401	10,561	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	23,056	3,944	8,369	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	15,825	0	7,718	0	54.00
60.00	06000	0	18,056	0	2,046	0	60.00
65.00	06500	0	7,941	0	0	0	65.00
66.00	06600	4,636	14,717	0	9,532	0	66.00
67.00	06700	0	2,557	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
68.01	03040	0	1,208	0	0	0	68.01
71.00	07100	0	2,486	1	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	5,341	0	0	0	73.00
76.97	07697	0	3,736	608	930	0	76.97
76.98	07698	0	5,015	0	558	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	3,296	0	0	0	90.00
91.00	09100	2,180	22,261	3,632	6,974	35	91.00
92.00	09200						92.00
93.00	04950	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		127,322	198,131	17,176	92,528	10,596	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	284	0	2,883	96	192.00
194.00	07950	28,241	1,321	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		155,563	199,736	17,176	95,411	10,692	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141336

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

Worksheet B
Part II
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Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	01160					5.01
5.02	00550					5.02
5.03	00560					5.03
5.04	00570					5.04
5.05	00580					5.05
5.06	00590					5.06
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
16.00	01600					16.00
17.00	01700					17.00
19.00	01900	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000		1,270,935	0	1,270,935	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000		1,033,258	0	1,033,258	50.00
53.00	05300		15,238	0	15,238	53.00
54.00	05400		1,197,811	0	1,197,811	54.00
60.00	06000		292,313	0	292,313	60.00
65.00	06500		135,874	0	135,874	65.00
66.00	06600		342,291	0	342,291	66.00
67.00	06700		8,077	0	8,077	67.00
68.00	06800		993	0	993	68.00
68.01	03040		33,457	0	33,457	68.01
71.00	07100		348,178	0	348,178	71.00
72.00	07200		35,652	0	35,652	72.00
73.00	07300		121,323	0	121,323	73.00
76.97	07697		94,799	0	94,799	76.97
76.98	07698		35,351	0	35,351	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000		9,556	0	9,556	90.00
91.00	09100		524,050	0	524,050	91.00
92.00	09200			0		92.00
93.00	04950		132,652	0	132,652	93.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		0	5,631,808	0	5,631,808	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000		40,739	0	40,739	190.00
192.00	19200		245,747	0	245,747	192.00
194.00	07950		30,489	0	30,489	194.00
194.01	07951		0	0	0	194.01
200.00		0	0	0	0	200.00
201.00		0	5,248	0	5,248	201.00
202.00		0	5,954,031	0	5,954,031	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141336

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

Worksheet B-1

Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (TELEPHONES)	DATA PROCESSING (TIME SPENT)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	97,100				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,076,417			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,235	11,638,161		4.00
5.01 01160	COMMUNICATIONS	0	15,431	0	778	5.01
5.02 00550	DATA PROCESSING	1,584	203,019	0	131	3,521 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	3,008	127,819	13	237 5.03
5.04 00570	ADMINISTRATIVE	913	26,323	355,033	14	451 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,014	175,257	21	0 5.05
5.06 00590	OTHER ADMIN & GENERAL	11,320	23,900	1,459,973	74	1,926 5.06
6.00 00600	MAINTENANCE & REPAIRS	0	2,989	229,800	13	0 6.00
7.00 00700	OPERATION OF PLANT	5,091	12,589	164,274	0	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	2,054	4,468	292,579	5	0 9.00
10.00 01000	DIETARY	2,634	6,144	400,617	13	78 10.00
11.00 01100	CAFETERIA	2,426	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	938	367,163	0	0 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,208	3,696	215,607	33	171 16.00
17.00 01700	SOCIAL SERVICE	0	1	178,206	2	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,606	108,157	1,905,044	89	262 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	14,901	264,312	997,909	30	84 50.00
53.00 05300	ANESTHESIOLOGY	0	10,505	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,170	869,102	795,765	22	0 54.00
60.00 06000	LABORATORY	3,143	63,023	641,133	24	173 60.00
65.00 06500	RESPIRATORY THERAPY	2,081	13,030	305,866	22	0 65.00
66.00 06600	PHYSICAL THERAPY	5,580	12,188	665,995	38	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	132,318	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	343	17,791	0	0 68.00
68.01 03040	AUDIOLOGY	564	1,716	84,568	0	0 68.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	4,662	63,818	66,799	12	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,179	10,159	461,756	13	0 73.00
76.97 07697	CARDIAC REHABILITATION	1,508	9,439	197,588	23	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	14,318	195,428	16	0 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	92,244	0	0 90.00
91.00 09100	EMERGENCY	7,217	48,197	1,086,173	29	139 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0 92.00
93.00 04950	O/P GERIATRIC PSYCH CENTER	2,478	1,429	273	0	0 93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	96,319	1,795,491	11,612,978	637	3,521 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT FLOWER COFFEE SHOP & CAN	781	847	0	0	0 190.00
192.00 19200	PHYSICIANS PRIVATE OFFICES	0	280,079	0	141	0 192.00
194.00 07950	TRANSPORTATION	0	0	25,183	0	0 194.00
194.01 07951	FUND DEVELOPMENT	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,331,069	1,622,962	2,954,874	6,813	2,993,289 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	44.604212	0.781617	0.253895	8.757069	850.124680 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			965	12,061	230,483 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000083	8.757069	65.459529 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141336

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

Worksheet B-1
Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		PURCHASING RECEIVING AND STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560	2,672,992					5.03
5.04	00570	6,280	31,556,571				5.04
5.05	00580	164	0	97,764,737			5.05
5.06	00590	35,009	0	0	-5,760,716	27,809,093	5.06
6.00	00600	4,486	0	0	0	309,615	6.00
7.00	00700	1,498	0	0	0	933,910	7.00
8.00	00800	697	0	0	0	119,374	8.00
9.00	00900	2,116	0	0	0	545,337	9.00
10.00	01000	2,085	0	0	0	803,955	10.00
11.00	01100	0	0	0	0	108,210	11.00
13.00	01300	1,468	0	0	0	468,624	13.00
16.00	01600	1,501	0	0	0	585,108	16.00
17.00	01700	957	0	0	0	315,870	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,489	4,360,577	4,770,260	0	3,790,801	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	16,636	1,828,469	8,094,133	0	2,425,780	50.00
53.00	05300	209	1,160,992	3,223,204	0	154,696	53.00
54.00	05400	5,990	7,842,825	29,842,391	0	3,105,271	54.00
60.00	06000	2,984	4,946,075	19,404,021	0	1,794,716	60.00
65.00	06500	4,241	1,012,316	2,155,636	0	575,152	65.00
66.00	06600	2,949	1,051,688	3,632,040	0	1,168,217	66.00
67.00	06700	23	417,140	544,721	0	183,606	67.00
68.00	06800	0	40,137	80,469	0	25,925	68.00
68.01	03040	1,663	0	259,204	0	142,072	68.01
71.00	07100	1,607,667	2,299,546	3,890,986	0	2,292,813	71.00
72.00	07200	919,064	1,212,385	1,806,775	0	1,108,515	72.00
73.00	07300	2,218	4,304,756	7,958,745	0	1,632,907	73.00
76.97	07697	1,588	0	663,287	0	331,824	76.97
76.98	07698	3,677	0	2,395,063	0	616,216	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	886	0	382,958	0	120,105	90.00
91.00	09100	3,591	1,079,665	8,095,298	0	3,243,440	91.00
92.00	09200						92.00
93.00	04950	673	0	565,546	0	546,564	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1-117)		2,635,809	31,556,571	97,764,737	-5,760,716	27,448,623	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	37,028	0	0	0	93,092	190.00
192.00	19200	37	0	0	0	231,022	192.00
194.00	07950	118	0	0	0	36,356	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		403,502	899,948	873,228		5,760,716	202.00
203.00		0.150955	0.028519	0.008932		0.207152	203.00
204.00		17,990	91,015	1,774		650,681	204.00
205.00		0.006730	0.002884	0.000018		0.023398	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141336

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

Worksheet B-1

Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600	4,149					6.00
7.00	00700	0	78,192				7.00
8.00	00800	175	0	171,927			8.00
9.00	00900	410	2,054	0	15,227		9.00
10.00	01000	182	2,634	2,324	1	92,752	10.00
11.00	01100	2	2,426	0	361	46,636	11.00
13.00	01300	176	0	0	20	0	13.00
16.00	01600	112	1,208	0	30	0	16.00
17.00	01700	0	0	0	1	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	854	17,606	77,686	6,064	25,214	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	230	14,901	23,725	1,081	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	117	8,170	15,612	896	0	54.00
60.00	06000	95	3,143	0	516	0	60.00
65.00	06500	25	2,081	3,050	166	0	65.00
66.00	06600	59	5,580	11,876	700	2,764	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
68.01	03040	2	564	0	70	0	68.01
71.00	07100	27	4,662	617	142	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	44	1,179	0	68	0	73.00
76.97	07697	60	1,508	0	230	0	76.97
76.98	07698	58	0	4,554	490	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1	0	0	451	0	90.00
91.00	09100	826	7,217	31,208	1,890	1,300	91.00
92.00	09200						92.00
93.00	04950	0	2,478	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,455	77,411	170,652	13,177	75,914	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	78	781	0	6	0	190.00
192.00	19200	585	0	1,275	2,044	0	192.00
194.00	07950	31	0	0	0	16,838	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		373,752	1,127,371	159,867	724,854	1,027,077	202.00
203.00		90.082430	14.417984	0.929854	47.603205	11.073368	203.00
204.00		9,743	258,796	3,209	115,712	155,563	204.00
205.00		2.348277	3.309750	0.018665	7.599133	1.677193	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141336

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

Worksheet B-1

Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		CAFETERIA (MEALS FTES)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	14,060					11.00
13.00	01300	343	148,200				13.00
16.00	01600	630	0	2,052			16.00
17.00	01700	229	0	0	2,120		17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,911	77,581	1,213	2,094	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,623	34,028	180	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	1,114	0	166	0	0	54.00
60.00	06000	1,271	0	44	0	0	60.00
65.00	06500	559	0	0	0	0	65.00
66.00	06600	1,036	0	205	0	0	66.00
67.00	06700	180	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
68.01	03040	85	0	0	0	0	68.01
71.00	07100	175	8	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	376	0	0	0	0	73.00
76.97	07697	263	5,248	20	0	0	76.97
76.98	07698	353	0	12	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	232	0	0	0	0	90.00
91.00	09100	1,567	31,335	150	7	0	91.00
92.00	09200						92.00
93.00	04950	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		13,947	148,200	1,990	2,101	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	20	0	62	19	0	192.00
194.00	07950	93	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		699,387	599,569	766,586	392,742	0	202.00
203.00		49.743030	4.045675	373.579922	185.255660	0.000000	203.00
204.00		199,736	17,176	95,411	10,692	0	204.00
205.00		14.205974	0.115897	46.496589	5.043396	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141336

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

Worksheet C
Part I
Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	6,896,450		6,896,450	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,523,009		3,523,009	0	0	50.00
53.00	05300 ANESTHESIOLOGY	186,742		186,742	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,051,466		4,051,466	0	0	54.00
60.00	06000 LABORATORY	2,324,593		2,324,593	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	765,096	0	765,096	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,699,072	0	1,699,072	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	230,594	0	230,594	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	31,295	0	31,295	0	0	68.00
68.01	03040 AUDIOLOGY	187,374	0	187,374	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2,853,494		2,853,494	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,338,146		1,338,146	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,014,070		2,014,070	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	480,444		480,444	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	798,694		798,694	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	178,084		178,084	0	0	90.00
91.00	09100 EMERGENCY	4,489,224		4,489,224	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	425,490		425,490	0	0	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	695,514		695,514	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	33,168,851	0	33,168,851	0	0	200.00
201.00	Less Observation Beds	425,490		425,490			201.00
202.00	Total (see instructions)	32,743,361	0	32,743,361	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141336

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

Worksheet C
Part I
Date/Time Prepared:
11/18/2016 11:57 am

		Title XVII			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	4,228,170		4,228,170		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,786,978	6,307,155	8,094,133	0.435255	50.00
53.00	05300	ANESTHESIOLOGY	1,164,841	2,058,363	3,223,204	0.057937	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,116,164	25,726,227	29,842,391	0.135762	54.00
60.00	06000	LABORATORY	4,989,591	14,414,430	19,404,021	0.119800	60.00
65.00	06500	RESPIRATORY THERAPY	1,012,316	1,143,320	2,155,636	0.354928	65.00
66.00	06600	PHYSICAL THERAPY	1,051,688	2,580,352	3,632,040	0.467801	66.00
67.00	06700	OCCUPATIONAL THERAPY	417,140	127,581	544,721	0.423325	67.00
68.00	06800	SPEECH PATHOLOGY	40,137	40,332	80,469	0.388908	68.00
68.01	03040	AUDIOLOGY	0	259,204	259,204	0.722882	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,299,546	1,591,440	3,890,986	0.733360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,212,385	594,390	1,806,775	0.740627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,303,968	3,654,777	7,958,745	0.253064	73.00
76.97	07697	CARDIAC REHABILITATION	0	663,287	663,287	0.724338	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,395,063	2,395,063	0.333475	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	382,958	382,958	0.465022	90.00
91.00	09100	EMERGENCY	1,079,665	7,015,633	8,095,298	0.554547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	132,407	409,683	542,090	0.784907	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	565,546	565,546	1.229810	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	27,834,996	69,929,741	97,764,737		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	27,834,996	69,929,741	97,764,737		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/18/2016 11:57 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
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
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
68.01	03040 AUDIOLOGY	0.000000		68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	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
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000		92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	0.000000		93.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141336

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

Worksheet C
Part I
Date/Time Prepared:
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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	6,896,450		6,896,450	0	6,896,450 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,523,009		3,523,009	0	3,523,009 50.00
53.00	05300 ANESTHESIOLOGY	186,742		186,742	0	186,742 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,051,466		4,051,466	0	4,051,466 54.00
60.00	06000 LABORATORY	2,324,593		2,324,593	0	2,324,593 60.00
65.00	06500 RESPIRATORY THERAPY	765,096	0	765,096	0	765,096 65.00
66.00	06600 PHYSICAL THERAPY	1,699,072	0	1,699,072	0	1,699,072 66.00
67.00	06700 OCCUPATIONAL THERAPY	230,594	0	230,594	0	230,594 67.00
68.00	06800 SPEECH PATHOLOGY	31,295	0	31,295	0	31,295 68.00
68.01	03040 AUDIOLOGY	187,374	0	187,374	0	187,374 68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	2,853,494		2,853,494	0	2,853,494 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,338,146		1,338,146	0	1,338,146 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,014,070		2,014,070	0	2,014,070 73.00
76.97	07697 CARDIAC REHABILITATION	480,444		480,444	0	480,444 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	798,694		798,694	0	798,694 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	178,084		178,084	0	178,084 90.00
91.00	09100 EMERGENCY	4,489,224		4,489,224	0	4,489,224 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	425,490		425,490	0	425,490 92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	695,514		695,514	0	695,514 93.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	33,168,851	0	33,168,851	0	33,168,851 200.00
201.00	Less Observation Beds	425,490		425,490		425,490 201.00
202.00	Total (see instructions)	32,743,361	0	32,743,361	0	32,743,361 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141336

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

Worksheet C
Part I
Date/Time Prepared:
11/18/2016 11:57 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	4,228,170		4,228,170		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,786,978	6,307,155	8,094,133	0.435255	50.00
53.00	05300	ANESTHESIOLOGY	1,164,841	2,058,363	3,223,204	0.057937	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,116,164	25,726,227	29,842,391	0.135762	54.00
60.00	06000	LABORATORY	4,989,591	14,414,430	19,404,021	0.119800	60.00
65.00	06500	RESPIRATORY THERAPY	1,012,316	1,143,320	2,155,636	0.354928	65.00
66.00	06600	PHYSICAL THERAPY	1,051,688	2,580,352	3,632,040	0.467801	66.00
67.00	06700	OCCUPATIONAL THERAPY	417,140	127,581	544,721	0.423325	67.00
68.00	06800	SPEECH PATHOLOGY	40,137	40,332	80,469	0.388908	68.00
68.01	03040	AUDIOLOGY	0	259,204	259,204	0.722882	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,299,546	1,591,440	3,890,986	0.733360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,212,385	594,390	1,806,775	0.740627	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,303,968	3,654,777	7,958,745	0.253064	73.00
76.97	07697	CARDIAC REHABILITATION	0	663,287	663,287	0.724338	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,395,063	2,395,063	0.333475	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	382,958	382,958	0.465022	90.00
91.00	09100	EMERGENCY	1,079,665	7,015,633	8,095,298	0.554547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	132,407	409,683	542,090	0.784907	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	565,546	565,546	1.229810	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	27,834,996	69,929,741	97,764,737		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	27,834,996	69,929,741	97,764,737		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/18/2016 11:57 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
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
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
68.01	03040 AUDIOLOGY	0.000000		68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	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
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000		92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	0.000000		93.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/18/2016 11:57 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	1,033,258	8,094,133	0.127655	935,024	119,360	50.00
53.00	05300 ANESTHESIOLOGY	15,238	3,223,204	0.004728	436,489	2,064	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,197,811	29,842,391	0.040138	1,361,662	54,654	54.00
60.00	06000 LABORATORY	292,313	19,404,021	0.015065	1,808,212	27,241	60.00
65.00	06500 RESPIRATORY THERAPY	135,874	2,155,636	0.063032	398,456	25,115	65.00
66.00	06600 PHYSICAL THERAPY	342,291	3,632,040	0.094242	252,151	23,763	66.00
67.00	06700 OCCUPATIONAL THERAPY	8,077	544,721	0.014828	63,585	943	67.00
68.00	06800 SPEECH PATHOLOGY	993	80,469	0.012340	14,284	176	68.00
68.01	03040 AUDIOLOGY	33,457	259,204	0.129076	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	348,178	3,890,986	0.089483	1,035,459	92,656	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	35,652	1,806,775	0.019732	724,568	14,297	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	121,323	7,958,745	0.015244	1,524,279	23,236	73.00
76.97	07697 CARDIAC REHABILITATION	94,799	663,287	0.142923	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	35,351	2,395,063	0.014760	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	9,556	382,958	0.024953	0	0	90.00
91.00	09100 EMERGENCY	524,050	8,095,298	0.064735	38,866	2,516	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	78,413	542,090	0.144649	8,190	1,185	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	132,652	565,546	0.234556	0	0	93.00
200.00	Total (Lines 50-199)	4,439,286	93,536,567		8,601,225	387,206	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/18/2016 11:57 am
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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)	
		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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
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
68.01	03040	AUDIOLOGY	0	0	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
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	0	0	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141336

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

Worksheet D
Part IV
Date/Time Prepared:
11/18/2016 11:57 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		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,094,133	0.000000	0.000000	935,024	50.00
53.00	05300	ANESTHESIOLOGY	0	3,223,204	0.000000	0.000000	436,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,842,391	0.000000	0.000000	1,361,662	54.00
60.00	06000	LABORATORY	0	19,404,021	0.000000	0.000000	1,808,212	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,155,636	0.000000	0.000000	398,456	65.00
66.00	06600	PHYSICAL THERAPY	0	3,632,040	0.000000	0.000000	252,151	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	544,721	0.000000	0.000000	63,585	67.00
68.00	06800	SPEECH PATHOLOGY	0	80,469	0.000000	0.000000	14,284	68.00
68.01	03040	AUDIOLOGY	0	259,204	0.000000	0.000000	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	3,890,986	0.000000	0.000000	1,035,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,806,775	0.000000	0.000000	724,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,958,745	0.000000	0.000000	1,524,279	73.00
76.97	07697	CARDIAC REHABILITATION	0	663,287	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,395,063	0.000000	0.000000	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	382,958	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	8,095,298	0.000000	0.000000	38,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	542,090	0.000000	0.000000	8,190	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	565,546	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	93,536,567			8,601,225	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141336

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

Worksheet D
Part IV
Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		Title XVIII			Hospital	Cost
		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
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
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
68.01	03040 AUDIOLOGY	0	0	0		68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	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
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	0		92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	0	0	0		93.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/18/2016 11:57 am
	Title XVIII	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	0.435255	0	2,183,901	0	0
53.00 05300 ANESTHESIOLOGY	0.057937	0	464,846	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.135762	0	9,565,733	0	0
60.00 06000 LABORATORY	0.119800	0	4,794,687	0	0
65.00 06500 RESPIRATORY THERAPY	0.354928	0	430,989	0	0
66.00 06600 PHYSICAL THERAPY	0.467801	0	889,817	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.423325	0	31,528	0	0
68.00 06800 SPEECH PATHOLOGY	0.388908	0	7,323	0	0
68.01 03040 AUDIOLOGY	0.722882	0	33,420	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.733360	0	707,232	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.740627	0	252,390	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.253064	0	1,198,338	18,397	0
76.97 07697 CARDIAC REHABILITATION	0.724338	0	339,802	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.333475	0	1,099,964	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.465022	0	58,908	0	0
91.00 09100 EMERGENCY	0.554547	0	2,237,440	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0.784907	0	268,192	0	0
93.00 04950 O/P GERIATRIC PSYCH CENTER	1.229810	0	505,558	0	0
200.00 Subtotal (see instructions)		0	25,070,068	18,397	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	25,070,068	18,397	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/18/2016 11:57 am
		Title XVIII	Hospital	Cost

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	950,554	0	50.00
53.00	05300 ANESTHESIOLOGY	26,932	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,298,663	0	54.00
60.00	06000 LABORATORY	574,404	0	60.00
65.00	06500 RESPIRATORY THERAPY	152,970	0	65.00
66.00	06600 PHYSICAL THERAPY	416,257	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	13,347	0	67.00
68.00	06800 SPEECH PATHOLOGY	2,848	0	68.00
68.01	03040 AUDIOLOGY	24,159	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	518,656	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	186,927	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	303,256	4,656	73.00
76.97	07697 CARDIAC REHABILITATION	246,132	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	366,810	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	27,394	0	90.00
91.00	09100 EMERGENCY	1,240,766	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	210,506	0	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	621,740	0	93.00
200.00	Subtotal (see instructions)	7,182,321	4,656	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	7,182,321	4,656	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141336

Period: From 07/01/2015

Worksheet D

Component CCN: 14Z336

To 06/30/2016

Part V
Date/Time Prepared:
11/18/2016 11:57 am

Title XVIII

Swing Beds - SNF

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	0.435255	0	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0.057937	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.135762	0	0	0	0	54.00
60.00 06000 LABORATORY	0.119800	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.354928	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.467801	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.423325	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.388908	0	0	0	0	68.00
68.01 03040 AUDIOLOGY	0.722882	0	0	0	0	68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.733360	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.740627	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.253064	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0.724338	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.333475	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.465022	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.554547	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0.784907	0	0	0	0	92.00
93.00 04950 O/P GERIATRIC PSYCH CENTER	1.229810	0	0	0	0	93.00
200.00 Subtotal (see instructions)		0	0	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	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141336 Component CCN: 14Z336	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/18/2016 11:57 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			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	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
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
68.01	03040	AUDIOLOGY	0	0	68.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
93.00	04950	O/P GERIATRIC PSYCH CENTER	0	0	93.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/18/2016 11:57 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.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.435255	0	234,368	0	0 50.00
53.00 05300 ANESTHESIOLOGY	0.057937	0	29,938	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.135762	0	1,065,832	0	0 54.00
60.00 06000 LABORATORY	0.119800	0	465,141	0	0 60.00
65.00 06500 RESPIRATORY THERAPY	0.354928	0	112,632	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.467801	0	1,261	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.423325	0	473	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.388908	0	415	0	0 68.00
68.01 03040 AUDIOLOGY	0.722882	0	0	0	0 68.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.733360	0	49,872	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.740627	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.253064	0	170,544	0	0 73.00
76.97 07697 CARDIAC REHABILITATION	0.724338	0	37,614	0	0 76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.333475	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.465022	0	2,801	0	0 90.00
91.00 09100 EMERGENCY	0.554547	0	692,483	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0.784907	0	33,417	0	0 92.00
93.00 04950 O/P GERIATRIC PSYCH CENTER	1.229810	0	0	0	0 93.00
200.00 Subtotal (see instructions)		0	2,896,791	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	2,896,791	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/18/2016 11:57 am
		Title XIX	Hospital	Cost

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	102,010	0	50.00
53.00	05300 ANESTHESIOLOGY	1,735	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	144,699	0	54.00
60.00	06000 LABORATORY	55,724	0	60.00
65.00	06500 RESPIRATORY THERAPY	39,976	0	65.00
66.00	06600 PHYSICAL THERAPY	590	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	200	0	67.00
68.00	06800 SPEECH PATHOLOGY	161	0	68.00
68.01	03040 AUDIOLOGY	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	36,574	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	43,159	0	73.00
76.97	07697 CARDIAC REHABILITATION	27,245	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1,303	0	90.00
91.00	09100 EMERGENCY	384,014	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	26,229	0	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	0	0	93.00
200.00	Subtotal (see instructions)	863,619	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	863,619	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 11/18/2016 11:57 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)		6,895	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,842	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)		3,423	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)		2,926	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		63	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)		64	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,103	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)		2,512	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		183.92	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		188.52	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,896,450	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)		11,587	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)		12,065	25.00
26.00	Total swing-bed cost (see instructions)		2,994,946	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,901,504	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)		3,901,504	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)		1,015.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,135,554	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,135,554	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/18/2016 11:57 am
Title XVIII			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,835,320 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,970,874 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)					2,550,886 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,550,886 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)					419 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,015.49 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					425,490 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141336		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/18/2016 11:57 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	1,270,935	6,896,450	0.184288	425,490	78,413	90.00
91.00	Nursing School cost	0	6,896,450	0.000000	425,490	0	91.00
92.00	Allied health cost	0	6,896,450	0.000000	425,490	0	92.00
93.00	All other Medical Education	0	6,896,450	0.000000	425,490	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/18/2016 11:57 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		1,961,830		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.435255	935,024	406,974	50.00
53.00	05300 ANESTHESIOLOGY	0.057937	436,489	25,289	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135762	1,361,662	184,862	54.00
60.00	06000 LABORATORY	0.119800	1,808,212	216,624	60.00
65.00	06500 RESPIRATORY THERAPY	0.354928	398,456	141,423	65.00
66.00	06600 PHYSICAL THERAPY	0.467801	252,151	117,956	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.423325	63,585	26,917	67.00
68.00	06800 SPEECH PATHOLOGY	0.388908	14,284	5,555	68.00
68.01	03040 AUDIOLOGY	0.722882	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.733360	1,035,459	759,364	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.740627	724,568	536,635	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253064	1,524,279	385,740	73.00
76.97	07697 CARDIAC REHABILITATION	0.724338	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.333475	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.465022	0	0	90.00
91.00	09100 EMERGENCY	0.554547	38,866	21,553	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.784907	8,190	6,428	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	1.229810	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		8,601,225	2,835,320	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)		8,601,225		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3	
		Component CCN: 14Z336		Date/Time Prepared: 11/18/2016 11:57 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.435255	5,315	2,313	50.00
53.00	05300 ANESTHESIOLOGY	0.057937	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135762	221,056	30,011	54.00
60.00	06000 LABORATORY	0.119800	823,582	98,665	60.00
65.00	06500 RESPIRATORY THERAPY	0.354928	340,176	120,738	65.00
66.00	06600 PHYSICAL THERAPY	0.467801	539,763	252,502	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.423325	257,522	109,016	67.00
68.00	06800 SPEECH PATHOLOGY	0.388908	18,264	7,103	68.00
68.01	03040 AUDIOLOGY	0.722882	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.733360	392,531	287,867	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.740627	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253064	1,179,606	298,516	73.00
76.97	07697 CARDIAC REHABILITATION	0.724338	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.333475	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.465022	0	0	90.00
91.00	09100 EMERGENCY	0.554547	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.784907	0	0	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	1.229810	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		3,777,815	1,206,731	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)		3,777,815		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/18/2016 11:57 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		52,547		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.435255	38,644	16,820	50.00
53.00	05300 ANESTHESIOLOGY	0.057937	16,380	949	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135762	61,926	8,407	54.00
60.00	06000 LABORATORY	0.119800	62,368	7,472	60.00
65.00	06500 RESPIRATORY THERAPY	0.354928	11,222	3,983	65.00
66.00	06600 PHYSICAL THERAPY	0.467801	2,974	1,391	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.423325	609	258	67.00
68.00	06800 SPEECH PATHOLOGY	0.388908	0	0	68.00
68.01	03040 AUDIOLOGY	0.722882	0	0	68.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.733360	36,389	26,686	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.740627	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.253064	66,460	16,819	73.00
76.97	07697 CARDIAC REHABILITATION	0.724338	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.333475	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.465022	0	0	90.00
91.00	09100 EMERGENCY	0.554547	5,241	2,906	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.784907	1,329	1,043	92.00
93.00	04950 O/P GERIATRIC PSYCH CENTER	1.229810	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		303,542	86,734	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)		303,542		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/18/2016 11:57 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,186,977 1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7,186,977 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)			7,258,847 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)			30,859 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			4,087,213 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			3,140,775 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,140,775 30.00
31.00	Primary payer payments			1,693 31.00
32.00	Subtotal (line 30 minus line 31)			3,139,082 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)			392,226 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			254,947 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			267,712 36.00
37.00	Subtotal (see instructions)			3,394,029 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,394,029 40.00
40.01	Sequestration adjustment (see instructions)			67,881 40.01
41.00	Interim payments			4,276,083 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-949,935 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141336

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

Worksheet E-1
Part I
Date/Time Prepared:
11/18/2016 11:57 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		4,330,173		4,276,083	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)		4,330,173		4,276,083	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		100,667		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		949,935	6.02	
7.00	Total Medicare program liability (see instructions)		4,430,840		3,326,148	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: 141336
Component CCN: 14Z336

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

Worksheet E-1
Part I
Date/Time Prepared:
11/18/2016 11:57 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,978,879		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,978,879		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		318,830		0	6.02
7.00	Total Medicare program liability (see instructions)		3,660,049		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141336

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

Worksheet E-1
Part II
Date/Time Prepared:
11/18/2016 11:57 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			1,020	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2,103	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			459	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			3,423	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			97,764,737	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			2,694,736	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			1	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet E-2
		Component CCN: 14Z336	Date/Time Prepared: 11/18/2016 11:57 am	
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,576,395	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	1,218,798	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	2,512	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3,795,193	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	3,795,193	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	3,795,193	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	60,449	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	3,734,744	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	3,734,744	0	19.00
19.01	Sequestration adjustment (see instructions)	74,695	0	19.01
20.00	Interim payments	3,978,879	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-318,830	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141336	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part V Date/Time Prepared: 11/18/2016 11:57 am
		Title XVII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			4,970,874 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)			4,970,874 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5,020,583 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			5,020,583 19.00
20.00	Deductibles (exclude professional component)			544,012 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			4,476,571 22.00
23.00	Coinurance			2,849 23.00
24.00	Subtotal (line 22 minus line 23)			4,473,722 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			73,143 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			47,543 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			28,131 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4,521,265 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			4,521,265 30.00
30.01	Sequestration adjustment (see instructions)			90,425 30.01
31.00	Interim payments			4,330,173 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)			100,667 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

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

Provider CCN: 141336

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

Worksheet G

Date/Time Prepared:
11/18/2016 11:57 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	3,353,569	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	17,731,554	0	0	0	4.00
5.00	Other receivable	-5,250	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,830,624	0	0	0	6.00
7.00	Inventory	576,552	0	0	0	7.00
8.00	Prepaid expenses	266,100	0	0	0	8.00
9.00	Other current assets	-87,289	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,004,612	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,130,878	0	0	0	12.00
13.00	Land improvements	1,354,010	0	0	0	13.00
14.00	Accumulated depreciation	-694,025	0	0	0	14.00
15.00	Buildings	33,665,511	0	0	0	15.00
16.00	Accumulated depreciation	-4,012,393	0	0	0	16.00
17.00	Leasehold improvements	4,255,901	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	13,383,325	0	0	0	23.00
24.00	Accumulated depreciation	-7,794,962	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)	42,288,245	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	9,733,907	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,733,907	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	63,026,764	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	576,590	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,047,689	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	14,921,939	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	0	0	0	0	43.00
44.00	Other current liabilities	4,913,223	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	21,459,441	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	29,468,839	0	0	0	46.00
47.00	Notes payable	8,180,742	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,371,865	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	42,021,446	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	63,480,887	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-454,123	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-454,123	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	63,026,764	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141336

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

Worksheet G-1

Date/Time Prepared:
11/18/2016 11:57 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		-1,885,081		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,430,958				2.00
3.00	Total (sum of line 1 and line 2)		-454,123		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-454,123		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-454,123		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	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: 141336

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/18/2016 11:57 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,980,120		3,980,120	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,070,434		1,070,434	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,050,554		5,050,554	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,050,554		5,050,554	17.00
18.00	Ancillary services	26,576,411	59,951,020	86,527,431	18.00
19.00	Outpatient services	1,094,413	8,089,652	9,184,065	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER IDENTIFIED ON TB	0	82,822	82,822	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	32,721,378	68,123,494	100,844,872	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,974,648		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)		38,974,648		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141336

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

Worksheet G-3

Date/Time Prepared:
11/18/2016 11:57 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	100,844,872	1.00
2.00	Less contractual allowances and discounts on patients' accounts	60,491,521	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,353,351	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,974,648	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,378,703	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	3,784	13.00
14.00	Revenue from meals sold to employees and guests	148,142	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	490	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	5,168	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	43,397	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	52,460	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER IDENTIFIED ON TB	-201,186	24.00
25.00	Total other income (sum of lines 6-24)	52,255	25.00
26.00	Total (line 5 plus line 25)	1,430,958	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)	1,430,958	29.00