

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S Parts I-III Date/Time Prepared: 1/30/2017 11:12 am
--	----------------------	---------------------------------------	--

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: 1/30/2017	Time: 11:12 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 Kindred Hospital Chicago (142008) for the cost reporting period beginning 09/01/2015 and ending 08/31/2016 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	190,853	6,298	0	5,661,149	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	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
200.00 Total	0	190,853	6,298	0	5,661,149	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 12:13 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 365 East North Avenue		PO Box:						1.00		
2.00	City: Northlake		State: IL		Zip Code: 60164		County: Cook		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		Kinred Hospital Chicago	142008	16974	2	04/01/1991	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										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)					09/01/2015	08/31/2016		20.00		
21.00	Type of Control (see instructions)					4			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.						2	N	23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 12:13 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				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.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N		N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N		N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N		N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 12:13 pm	
	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	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		Teaching Hospitals that Claim Residents in Nonprovider Settings		0.00		62.01
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 12:13 pm		
		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.				Y	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	Y	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 12:13 pm		
		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.				N	110.00
					1.00	
					2.00	
					3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	165,992	0	1,365,212		118.01
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00		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: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/25/2017 12:13 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00
			1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part II Date/Time Prepared: 1/25/2017 12:13 pm		
			Y/N	Date		
			1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPLETED BY ALL HOSPITALS						
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00	
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00	
			Y/N	Type	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2017	4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00	
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00	
				Y/N		
				1.00		
Bad Debts						
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00	
Bed Complement						
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00	
			Part A		Part B	
			Y/N	Date	Y/N	Date
			1.00	2.00	3.00	4.00
PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/31/2016	Y	10/31/2016	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)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part II Date/Time Prepared: 1/25/2017 12:13 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.		Y	12/31/2016	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		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.	DEBORAH	LANCASTER		41.00
42.00	Enter the employer/company name of the cost report preparer.	KINDRED HEALTHCARE OPERATING INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5025967593	Deborah.Lancaster@kindred.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.	REIMBURSEMENT DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
1/25/2017 12:13 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	244	89,304	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		244	89,304	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		244	89,304	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	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)		244				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: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
1/25/2017 12:13 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	17,969	13,447	56,240			1.00
2.00 HMO and other (see instructions)	3,168	18,592				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	17,969	13,447	56,240			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	17,969	13,447	56,240	0.00	502.90	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	0	0	0	0.00	0.00	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	502.90	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	888					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
1/25/2017 12:13 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	658	612	2,281	1.00
2.00 HMO and other (see instructions)			125	811		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	658	612	2,281	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	0.00					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 WAGE INDEX INFORMATION			Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 Part II Date/Time Prepared: 1/25/2017 12:13 pm			
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	29,662,782	0	29,662,782	1,046,362.06	28.35	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	5,258	5,258	112.00	46.95	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		4,991,102	0	4,991,102	86,285.00	57.84	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,413,445	0	1,413,445	13,816.00	102.30	13.00
14.00	Home office salaries & wage-related costs		4,382,855	0	4,382,855	71,850.09	61.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		4,386,776	0	4,386,776			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		778	0	778			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	233,237	0	233,237	4,666.19	49.98	26.00
27.00	Administrative & General	5.00	3,681,352	0	3,681,352	96,461.92	38.16	27.00
28.00	Administrative & General under contract (see inst.)		48,297	0	48,297	1,156.00	41.78	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	247,855	0	247,855	17,077.00	14.51	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	801,565	0	801,565	64,864.00	12.36	32.00
33.00	Housekeeping under contract (see instructions)		3,304	0	3,304	182.00	18.15	33.00
34.00	Dietary	10.00	860,139	0	860,139	52,590.00	16.36	34.00
35.00	Dietary under contract (see instructions)		56,907	0	56,907	2,719.00	20.93	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,577,424	0	1,577,424	36,479.00	43.24	38.00
39.00	Central Services and Supply	14.00	235,875	0	235,875	16,766.00	14.07	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet S-3
Part II
Date/Time Prepared:
1/25/2017 12:13 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	1,044,008	0	1,044,008	34,787.00	30.01	41.00
42.00	Social Service	17.00	1,258,585	-5,258	1,253,327	26,874.00	46.64	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet S-3
Part III
Date/Time Prepared:
1/25/2017 12:13 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	29,771,290	0	29,771,290	1,050,419.06	28.34	1.00
2.00	Excluded area salaries (see instructions)	0	5,258	5,258	112.00	46.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29,771,290	-5,258	29,766,032	1,050,307.06	28.34	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,787,402	0	10,787,402	171,951.09	62.74	4.00
5.00	Subtotal wage-related costs (see inst.)	4,386,776	0	4,386,776	0.00	14.74	5.00
6.00	Total (sum of lines 3 thru 5)	44,945,468	-5,258	44,940,210	1,222,258.15	36.77	6.00
7.00	Total overhead cost (see instructions)	10,048,548	-5,258	10,043,290	354,622.11	28.32	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 1/25/2017 12:13 pm
-----------------------------	----------------------	---	---

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	1,314,098	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-16,196	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	18,857	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	96,960	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	516,234	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,125,669	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	299,426	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	31,728	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,386,776	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		13,284,178	13,284,178	1,210,675	14,494,853	1.00
2.00	00200		1,756,365	1,756,365	542,138	2,298,503	2.00
3.00	00300		1,752,813	1,752,813	-1,752,813	0	3.00
4.00	00400	233,237	4,731,986	4,965,223	0	4,965,223	4.00
5.00	00500	3,681,352	17,739,945	21,421,297	0	21,421,297	5.00
7.00	00700	247,855	3,250,674	3,498,529	0	3,498,529	7.00
8.00	00800	0	334,708	334,708	0	334,708	8.00
9.00	00900	801,565	221,236	1,022,801	0	1,022,801	9.00
10.00	01000	860,139	952,029	1,812,168	0	1,812,168	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,577,424	38,116	1,615,540	0	1,615,540	13.00
14.00	01400	235,875	65,788	301,663	0	301,663	14.00
15.00	01500	0	1,932,837	1,932,837	0	1,932,837	15.00
16.00	01600	1,044,008	321,008	1,365,016	0	1,365,016	16.00
17.00	01700	1,258,585	63,303	1,321,888	-5,523	1,316,365	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	12,893,893	3,224,088	16,117,981	2,470,635	18,588,616	30.00
31.00	03100	2,373,879	96,756	2,470,635	-2,470,635	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	298,183	293,499	591,682	0	591,682	50.00
54.00	05400	261,503	146,644	408,147	0	408,147	54.00
60.00	06000	658,871	292,114	950,985	0	950,985	60.00
65.00	06500	3,192,455	73,421	3,265,876	0	3,265,876	65.00
66.00	06600	0	2,705,347	2,705,347	0	2,705,347	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	3,495,185	3,495,185	0	3,495,185	71.00
73.00	07300	0	3,380,727	3,380,727	0	3,380,727	73.00
74.00	07400	43,958	1,328,887	1,372,845	0	1,372,845	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		29,662,782	61,481,654	91,144,436	-5,523	91,138,913	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	5,523	5,523	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	9,230	9,230	0	9,230	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00		29,662,782	61,490,884	91,153,666	0	91,153,666	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	829,361	15,324,214	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	332,029	2,630,532	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-16,719	4,948,504	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,486,882	22,908,179	5.00
7.00	00700	OPERATION OF PLANT	-7,829	3,490,700	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	334,708	8.00
9.00	00900	HOUSEKEEPING	0	1,022,801	9.00
10.00	01000	DIETARY	-124,570	1,687,598	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-225	1,615,315	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	301,663	14.00
15.00	01500	PHARMACY	0	1,932,837	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,041	1,373,057	16.00
17.00	01700	SOCIAL SERVICE	0	1,316,365	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,389,685	17,198,931	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-319,029	272,653	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	408,147	54.00
60.00	06000	LABORATORY	-19,790	931,195	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,265,876	65.00
66.00	06600	PHYSICAL THERAPY	-207,585	2,497,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,495,185	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,380,727	73.00
74.00	07400	RENAL DIALYSIS	0	1,372,845	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	570,881	91,709,794	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	5,523	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	9,230	194.02
194.03	07953	DISTRICT OFFICE	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	194.11
200.00		TOTAL (SUM OF LINES 118-199)	570,881	91,724,547	200.00

RECLASSIFICATIONS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-6

Date/Time Prepared:
1/25/2017 12:13 pm

		Increases			
		Cost Center	Line #	Salary	Other
		2.00	3.00	4.00	5.00
A - RECLASS NON ALLOWABLE CASE MANAGER					
1.00	NONALLOWABLE CLINICAL		194.00	5,258	265
	LIASON				
	TOTALS			5,258	265
C - RECLASS ICU EXPENSE					
1.00	ADULTS & PEDIATRICS		30.00	2,373,879	96,756
	TOTALS			2,373,879	96,756
500.00	Grand Total: Increases			2,379,137	97,021

RECLASSIFICATIONS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-6

Date/Time Prepared:
1/25/2017 12:13 pm

		Decreases						
		Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
		6.00	7.00	8.00	9.00	10.00		
A - RECLASS NON ALLOWABLE CASE MANAGER								
1.00	SOCIAL SERVICE		17.00	5,258	265		0	1.00
	TOTALS			5,258	265			
C - RECLASS ICU EXPENSE								
1.00	INTENSIVE CARE UNIT		31.00	2,373,879	96,756		0	1.00
	TOTALS			2,373,879	96,756			
500.00	Grand Total: Decreases			2,379,137	97,021			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provi d e r C C N : 1 4 2 0 0 8

Peri o d :
From 09/01/2015
To 08/31/2016

Worksheet A-7
Part I
Date/Time Prepared:
1/25/2017 12:13 pm

		B e g i n n i n g B a l a n c e s	A c q u i s i t i o n s			D i s p o s a l s a n d R e t i r e m e n t s	
			P u r c h a s e s	D o n a t i o n	T o t a l		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	675,156	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	34,165,604	1,011,185	0	1,011,185	469	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,351,868	903,080	0	903,080	200,723	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	50,192,628	1,914,265	0	1,914,265	201,192	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	50,192,628	1,914,265	0	1,914,265	201,192	10.00
		Endi n g B a l a n c e	F u l l y D e p r e c i a t e d A s s e t s				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	675,156	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	35,176,320	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	16,054,225	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	51,905,701	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	51,905,701	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-7
Part II
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	395,065	12,889,113	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	676,257	1,080,108	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,071,322	13,969,221	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	13,284,178				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,756,365				2.00
3.00	Total (sum of lines 1-2)	0	15,040,543				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-7
Part III
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	35,851,476	0	35,851,476	0.690704	108,130	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,054,225	0	16,054,225	0.309296	48,421	2.00
3.00	Total (sum of lines 1-2)	51,905,701	0	51,905,701	1.000000	156,551	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	1,102,545	0	1,210,675	1,279,219	12,889,113	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	493,717	0	542,138	1,008,286	1,080,108	2.00
3.00	Total (sum of lines 1-2)	1,596,262	0	1,752,813	2,287,505	13,969,221	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	53,337	1,102,545	0	15,324,214	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	48,421	493,717	0	2,630,532	2.00
3.00	Total (sum of lines 1-2)	0	101,758	1,596,262	0	17,954,746	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-8

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
1.00	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-10,080		ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-67,323		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-7,829		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,713,996				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	3,440,155				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-124,570		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-6,499		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	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01 MISCELLANEOUS INCOME	B	-84,213		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-8

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center		Line #		
			1.00	2.00	3.00		4.00
33.02		0			0.00	0	33.02
33.03		0			0.00	0	33.03
33.04		0			0.00	0	33.04
33.05	OCCUPATIONAL INCENTIVE INCOME	A	-51,016	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06			0		0.00	0	33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	A	-17,940	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	A	-1,360,909	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09			0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	A	-203,415	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	A	-4,197	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	A	-86	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	A	-318,934	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	A	-1,803	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER OPERATING - CASH OVER SHORT	A	628	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
33.19			0		0.00	0	33.19
33.20	OTHER OPERATING - TRADE SHOW BOOTH	A	-2,440	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21			0		0.00	0	33.21
33.22			0		0.00	0	33.22
33.23	CHARITABLE CONTRIBUTIONS	A	-30,417	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24			0		0.00	0	33.24
33.25			0		0.00	0	33.25
33.26			0		0.00	0	33.26
33.27			0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	A	-156,838	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	A	-67,683	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30			0		0.00	0	33.30
33.31			0		0.00	0	33.31
33.32	RENT - OTHER	A	535,301	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	EMP BEN - ADMISSION BONUS	A	-15,849	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	A	-127,698	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35			0		0.00	0	33.35
33.36			0		0.00	0	33.36
33.37	PHYSICIAN BILLING COLLECTION FEES	A	-6,898	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38			0		0.00	0	33.38
33.39			0		0.00	0	33.39
33.40			0		0.00	0	33.40
33.41			0		0.00	0	33.41
33.42			0		0.00	0	33.42
33.43	DISTRICT OFFICE SALES AND MARKETING	A	-147,361	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	DISTRICT OFC SALES AND MKT BENEFITS	A	-16,719	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	A	-54,793	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	A	831,869	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	A	-183,352	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02			0		0.00	0	34.02
34.03	ASSET ADD-ON BLDG	A	52,285	CAP REL COSTS-BLDG & FIXT	1.00	9	34.03
34.04	ASSET ADD-ON MOV EQUIP	A	524,435	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.04
34.05			0		0.00	0	34.05
34.06			0		0.00	0	34.06
34.07			0		0.00	0	34.07
34.08	NON ALLOWABLE LOBBYING FEES	A	-19,040	ADMINISTRATIVE & GENERAL	5.00	0	34.08
34.09	NON ALLOWABLE DUES AND SUBSCRIPTIONS	A	-2,200	ADMINISTRATIVE & GENERAL	5.00	0	34.09
34.10			0		0.00	0	34.10
34.11			0		0.00	0	34.11
34.12			0		0.00	0	34.12
34.13	PATIENT PHONE - DEPREC EQUIP	A	-9,054	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.13
34.14			0		0.00	0	34.14

ADJUSTMENTS TO EXPENSES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-8

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
34.15		0			0	34.15
34.16		0			0	34.16
34.17		0			0	34.17
34.18		0			0	34.18
34.19		0			0	34.19
34.20		0			0	34.20
34.21		0			0	34.21
34.22		0			0	34.22
34.23		0			0	34.23
34.24		0			0	34.24
34.25		0			0	34.25
34.26	NONALLOW TAXI SVC	A	-447	ADMINISTRATIVE & GENERAL	5.00	0 34.26
34.27	NONALLOW GUARDIANSHIP	A	-199	MEDICAL RECORDS & LIBRARY	16.00	0 34.27
34.28			0		0.00	0 34.28
35.00			0		0.00	0 35.00
35.01			0		0.00	0 35.01
35.02			0		0.00	0 35.02
35.03			0		0.00	0 35.03
35.04			0		0.00	0 35.04
35.05			0		0.00	0 35.05
35.06	PHYSICIAN FEE ADJUSTMENT	A	-225	NURSING ADMINISTRATION	13.00	0 35.06
35.07			0		0.00	0 35.07
35.08			0		0.00	0 35.08
35.09	PHYSICIAN FEE ADJUSTMENT	A	29,973	MEDICAL RECORDS & LIBRARY	16.00	0 35.09
35.10			0		0.00	0 35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	-22,394	ADULTS & PEDIATRICS	30.00	0 35.11
35.12			0		0.00	0 35.12
35.13			0		0.00	0 35.13
35.14	PHYSICIAN FEE ADJUSTMENT	A	-7,349	OPERATING ROOM	50.00	0 35.14
35.15			0		0.00	0 35.15
35.16	PHYSICIAN FEE ADJUSTMENT	A	1	LABORATORY	60.00	0 35.16
35.17			0		0.00	0 35.17
35.18			0		0.00	0 35.18
35.19			0		0.00	0 35.19
35.20			0		0.00	0 35.20
35.21			0		0.00	0 35.21
35.22			0		0.00	0 35.22
35.23			0		0.00	0 35.23
35.24			0		0.00	0 35.24
35.25			0		0.00	0 35.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		570,881			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: 142008
 Period: From 09/01/2015 To 08/31/2016
 Worksheet A-8-1
 Date/Time Prepared: 1/25/2017 12:13 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	6,848,211	3,200,471
2.00	0.00			0	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	479,077	479,077
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	1,527,281	1,527,281
4.01	66.00	PHYSICAL THERAPY	Therapy Services	2,492,022	2,699,607
5.00	0			11,346,591	7,906,436

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

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

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

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

6.00	B	KH01	100.00	Admin & Gen	100.00	6.00
7.00	B	KH01	100.00	Cornerstone	100.00	7.00
8.00	B	KH01	100.00	Cornerstone	100.00	8.00
9.00	B	KH01	100.00	RehabCare	100.00	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: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-8-1

Date/Time Prepared:
1/25/2017 12:13 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	3,647,740	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-207,585	0		4.01
5.00	3,440,155			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	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00	Therapy Svcs		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: 142008

Period: From 09/01/2015 To 08/31/2016

Worksheet A-8-2

Date/Time Prepared: 1/25/2017 12:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	359,217	0	359,217	177,200	4,226	1.00
2.00	30.00	DR. B	11,025	11,025	0	177,200	0	2.00
3.00	30.00	DR. C	3,798	0	3,798	177,200	23	3.00
4.00	30.00	DR. D	1,000	1,000	0	177,200	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	30.00	DR. F	15,708	15,708	0	177,200	0	6.00
7.00	30.00	DR. G	610,163	610,163	0	177,200	0	7.00
8.00	30.00	DR. H	170	170	0	177,200	0	8.00
9.00	30.00	DR. I	66,938	66,938	0	177,200	0	9.00
10.00	30.00	DR. J	1,473	0	1,473	177,200	10	10.00
11.00	30.00	DR. K	822,369	0	822,369	177,200	8,224	11.00
12.00	60.00	DR. L	15,401	0	15,401	215,700	83	12.00
14.00	30.00	DR. N	60,375	60,375	0	177,200	0	14.00
15.00	30.00	DR. O	17,654	0	17,654	177,200	122	15.00
16.00	30.00	DR. P	5,801	0	5,801	177,200	35	16.00
17.00	30.00	DR. Q	15,116	15,116	0	177,200	0	17.00
18.00	16.00	DR. R	18,573	0	18,573	177,200	108	18.00
19.00	30.00	DR. S	5,930	5,930	0	177,200	0	19.00
20.00	30.00	DR. T	37,388	0	37,388	177,200	261	20.00
21.00	30.00	DR. U	293,178	293,178	0	177,200	0	21.00
22.00	50.00	DR. V	97,081	97,081	0	208,000	0	22.00
23.00	16.00	DR. W	11,400	0	11,400	177,200	65	23.00
24.00	50.00	DR. X	204,340	204,340	0	200,300	0	24.00
25.00	50.00	DR. Y	16,133	0	16,133	200,300	61	25.00
26.00	30.00	DR. Z	15,708	15,708	0	177,200	0	26.00
27.00	30.00	DR. AA	119,190	119,190	0	177,200	0	27.00
28.00	30.00	DR. AB	2,262	2,262	0	177,200	0	28.00
29.00	60.00	DR. AC	29,693	0	29,693	215,700	161	29.00
30.00	30.00	DR. AD	1,088	1,088	0	177,200	0	30.00
200.00			2,858,172	1,519,272	1,338,900		13,379	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	360,023	18,001	0	0	0	1.00
2.00	30.00	DR. B	0	0	0	0	0	2.00
3.00	30.00	DR. C	1,959	98	0	0	0	3.00
4.00	30.00	DR. D	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	30.00	DR. G	0	0	0	0	0	7.00
8.00	30.00	DR. H	0	0	0	0	0	8.00
9.00	30.00	DR. I	0	0	0	0	0	9.00
10.00	30.00	DR. J	852	43	0	0	0	10.00
11.00	30.00	DR. K	700,622	35,031	0	0	0	11.00
12.00	60.00	DR. L	8,607	430	0	0	0	12.00
14.00	30.00	DR. N	0	0	0	0	0	14.00
15.00	30.00	DR. O	10,393	520	0	0	0	15.00
16.00	30.00	DR. P	2,982	149	0	0	0	16.00
17.00	30.00	DR. Q	0	0	0	0	0	17.00
18.00	16.00	DR. R	9,201	460	0	0	0	18.00
19.00	30.00	DR. S	0	0	0	0	0	19.00
20.00	30.00	DR. T	22,235	1,112	0	0	0	20.00
21.00	30.00	DR. U	0	0	0	0	0	21.00
22.00	50.00	DR. V	0	0	0	0	0	22.00
23.00	16.00	DR. W	5,538	277	0	0	0	23.00
24.00	50.00	DR. X	0	0	0	0	0	24.00
25.00	50.00	DR. Y	5,874	294	0	0	0	25.00
26.00	30.00	DR. Z	0	0	0	0	0	26.00
27.00	30.00	DR. AA	0	0	0	0	0	27.00
28.00	30.00	DR. AB	0	0	0	0	0	28.00
29.00	60.00	DR. AC	16,696	835	0	0	0	29.00
30.00	30.00	DR. AD	0	0	0	0	0	30.00
200.00			1,144,982	57,250	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	360,023	0	0		1.00
2.00	30.00	DR. B	0	0	0	11,025		2.00
3.00	30.00	DR. C	0	1,959	1,839	1,839		3.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet A-8-2

Date/Time Prepared:
1/25/2017 12:13 pm

	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		
4.00	30.00	DR. D	0	0	0	1,000		4.00
5.00	0.00		0	0	0	0		5.00
6.00	30.00	DR. F	0	0	0	15,708		6.00
7.00	30.00	DR. G	0	0	0	610,163		7.00
8.00	30.00	DR. H	0	0	0	170		8.00
9.00	30.00	DR. I	0	0	0	66,938		9.00
10.00	30.00	DR. J	0	852	621	621		10.00
11.00	30.00	DR. K	0	700,622	121,747	121,747		11.00
12.00	60.00	DR. L	0	8,607	6,794	6,794		12.00
14.00	30.00	DR. N	0	0	0	60,375		14.00
15.00	30.00	DR. O	0	10,393	7,261	7,261		15.00
16.00	30.00	DR. P	0	2,982	2,819	2,819		16.00
17.00	30.00	DR. Q	0	0	0	15,116		17.00
18.00	16.00	DR. R	0	9,201	9,372	9,372		18.00
19.00	30.00	DR. S	0	0	0	5,930		19.00
20.00	30.00	DR. T	0	22,235	15,153	15,153		20.00
21.00	30.00	DR. U	0	0	0	293,178		21.00
22.00	50.00	DR. V	0	0	0	97,081		22.00
23.00	16.00	DR. W	0	5,538	5,862	5,862		23.00
24.00	50.00	DR. X	0	0	0	204,340		24.00
25.00	50.00	DR. Y	0	5,874	10,259	10,259		25.00
26.00	30.00	DR. Z	0	0	0	15,708		26.00
27.00	30.00	DR. AA	0	0	0	119,190		27.00
28.00	30.00	DR. AB	0	0	0	2,262		28.00
29.00	60.00	DR. AC	0	16,696	12,997	12,997		29.00
30.00	30.00	DR. AD	0	0	0	1,088		30.00
200.00			0	1,144,982	194,724	1,713,996		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142008

Period: From 09/01/2015 To 08/31/2016

Worksheet B Part I Date/Time Prepared: 1/25/2017 12:13 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	15,324,214	15,324,214			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,630,532		2,630,532		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,948,504	440,701	76,362	5,465,567	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,908,179	1,466,524	254,112	683,690	25,312,505
7.00 00700	OPERATION OF PLANT	3,490,700	2,800,789	485,307	46,031	6,822,827
8.00 00800	LAUNDRY & LINEN SERVICE	334,708	234,976	40,715	0	610,399
9.00 00900	HOUSEKEEPING	1,022,801	199,739	34,610	148,864	1,406,014
10.00 01000	DIETARY	1,687,598	810,638	140,463	159,742	2,798,441
11.00 01100	CAFETERIA	0	164,696	28,538	0	193,234
13.00 01300	NURSING ADMINISTRATION	1,615,315	113,240	19,622	292,954	2,041,131
14.00 01400	CENTRAL SERVICES & SUPPLY	301,663	739,682	128,168	43,806	1,213,319
15.00 01500	PHARMACY	1,932,837	286,721	49,682	0	2,269,240
16.00 01600	MEDICAL RECORDS & LIBRARY	1,373,057	179,176	31,047	193,890	1,777,170
17.00 01700	SOCIAL SERVICE	1,316,365	46,725	8,096	232,764	1,603,950
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,198,931	4,685,520	811,885	2,835,485	25,531,821
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	272,653	564,850	97,874	55,378	990,755
54.00 05400	RADIOLOGY-DIAGNOSTIC	408,147	207,076	35,881	48,566	699,670
60.00 06000	LABORATORY	931,195	219,337	38,006	122,364	1,310,902
65.00 06500	RESPIRATORY THERAPY	3,265,876	228,894	39,662	592,893	4,127,325
66.00 06600	PHYSICAL THERAPY	2,497,762	415,407	71,980	0	2,985,149
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,495,185	0	0	0	3,495,185
73.00 07300	DRUGS CHARGED TO PATIENTS	3,380,727	0	0	0	3,380,727
74.00 07400	RENAL DIALYSIS	1,372,845	98,373	17,046	8,164	1,496,428
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	91,709,794	13,903,064	2,409,056	5,464,591	90,066,192
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,406	10,120	0	68,526
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	NONALLOWABLE CLINICAL LIAISON	5,523	0	0	976	6,499
194.01 07951	IDLE SPACE	0	142,974	0	0	142,974
194.02 07952	REGIONAL OFFICE	9,230	576,048	99,815	0	685,093
194.03 07953	DISTRICT OFFICE	0	643,722	111,541	0	755,263
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05 07955	REG NURSG OFFICE	0	0	0	0	0
194.06 07956	CONTACT CENTER	0	0	0	0	0
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	0
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09 07958	VISITOR MEALS	0	0	0	0	0
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	91,724,547	15,324,214	2,630,532	5,465,567	91,724,547

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part I Date/Time Prepared: 1/25/2017 12:13 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	25,312,505				5.00	
7.00	00700	OPERATION OF PLANT	2,663,986	9,486,813			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	238,332	212,845	1,061,576		8.00	
9.00	00900	HOUSEKEEPING	548,981	180,927	0	2,135,922	9.00	
10.00	01000	DIETARY	1,092,657	734,289	0	172,482	4,797,869	10.00
11.00	01100	CAFETERIA	75,449	149,184	0	35,043	1,651,649	11.00
13.00	01300	NURSING ADMINISTRATION	796,964	102,575	0	24,094	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	473,743	670,015	0	157,384	0	14.00
15.00	01500	PHARMACY	886,029	259,716	0	61,006	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	693,900	162,301	0	38,124	0	16.00
17.00	01700	SOCIAL SERVICE	626,265	42,324	0	9,942	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,968,955	4,244,216	1,061,576	996,952	3,055,068	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	386,842	511,650	0	120,185	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	273,188	187,573	0	44,060	0	54.00
60.00	06000	LABORATORY	511,844	198,679	0	46,669	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,611,522	207,336	0	48,702	0	65.00
66.00	06600	PHYSICAL THERAPY	1,165,557	376,282	0	88,387	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,364,702	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,320,012	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	584,283	89,108	0	20,931	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,283,211	8,329,020	1,061,576	1,863,961	4,706,717	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,756	52,905	0	12,427	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	2,538	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	521,794	0	122,567	0	194.02
194.03	07953	DISTRICT OFFICE	0	583,094	0	136,967	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	91,152	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	25,312,505	9,486,813	1,061,576	2,135,922	4,797,869	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part I Date/Time Prepared: 1/25/2017 12:13 pm
---	--	----------------------	---	--

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	2,104,559					11.00
13.00	01300		3,061,897				13.00
14.00	01400	43,170	0	2,557,631			14.00
15.00	01500	0	0	17,578	3,493,569		15.00
16.00	01600	91,737	0	2,273	0	2,765,505	16.00
17.00	01700	70,152	0	73	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,403,041	3,015,505	33,309	80,102	1,345,389	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	21,585	46,392	1,150	0	22,531	50.00
54.00	05400	21,585	0	762	532	66,855	54.00
60.00	06000	80,945	0	8,408	0	214,570	60.00
65.00	06500	269,815	0	6,220	0	348,446	65.00
66.00	06600	0	0	1,464	0	86,863	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	2,486,382	0	97,426	71.00
73.00	07300	0	0	0	3,412,935	528,606	73.00
74.00	07400	5,396	0	12	0	54,819	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		2,104,559	3,061,897	2,557,631	3,493,569	2,765,505	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,104,559	3,061,897	2,557,631	3,493,569	2,765,505	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet B
Part I
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	2,352,706			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,352,706	53,088,640	0	53,088,640	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,101,090	0	2,101,090	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,294,225	0	1,294,225	54.00
60.00	06000	LABORATORY	0	2,372,017	0	2,372,017	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,619,366	0	6,619,366	65.00
66.00	06600	PHYSICAL THERAPY	0	4,703,702	0	4,703,702	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,443,695	0	7,443,695	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,642,280	0	8,642,280	73.00
74.00	07400	RENAL DIALYSIS	0	2,250,977	0	2,250,977	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,352,706	88,515,992	0	88,515,992	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	160,614	0	160,614	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	9,037	0	9,037	194.00
194.01	07951	IDLE SPACE	0	142,974	0	142,974	194.01
194.02	07952	REGIONAL OFFICE	0	1,329,454	0	1,329,454	194.02
194.03	07953	DISTRICT OFFICE	0	1,475,324	0	1,475,324	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	91,152	0	91,152	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,352,706	91,724,547	0	91,724,547	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part II Date/Time Prepared: 1/25/2017 12:13 pm
-------------------------------------	--	----------------------	---	---

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	440,701	76,362	517,063	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	622,683	1,466,524	254,112	2,343,319	5.00
7.00 00700	OPERATION OF PLANT	0	2,800,789	485,307	3,286,096	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	234,976	40,715	275,691	8.00
9.00 00900	HOUSEKEEPING	0	199,739	34,610	234,349	9.00
10.00 01000	DIETARY	0	810,638	140,463	951,101	10.00
11.00 01100	CAFETERIA	0	164,696	28,538	193,234	11.00
13.00 01300	NURSING ADMINISTRATION	0	113,240	19,622	132,862	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	739,682	128,168	867,850	14.00
15.00 01500	PHARMACY	0	286,721	49,682	336,403	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	179,176	31,047	210,223	16.00
17.00 01700	SOCIAL SERVICE	0	46,725	8,096	54,821	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	4,685,520	811,885	5,497,405	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	564,850	97,874	662,724	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	207,076	35,881	242,957	54.00
60.00 06000	LABORATORY	0	219,337	38,006	257,343	60.00
65.00 06500	RESPIRATORY THERAPY	0	228,894	39,662	268,556	65.00
66.00 06600	PHYSICAL THERAPY	0	415,407	71,980	487,387	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	98,373	17,046	115,419	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	622,683	13,903,064	2,409,056	16,934,803	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,406	10,120	68,526	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	92.00
194.01 07951	IDLE SPACE	0	142,974	0	142,974	194.01
194.02 07952	REGIONAL OFFICE	0	576,048	99,815	675,863	194.02
194.03 07953	DISTRICT OFFICE	0	643,722	111,541	755,263	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	622,683	15,324,214	2,630,532	18,577,429	517,063.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part II Date/Time Prepared: 1/25/2017 12:13 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	2,408,000				5.00	
7.00	00700	OPERATION OF PLANT	253,427	3,543,878			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	22,673	79,510	377,874		8.00	
9.00	00900	HOUSEKEEPING	52,225	67,587	0	368,244	9.00	
10.00	01000	DIETARY	103,945	274,300	0	29,737	1,374,196	10.00
11.00	01100	CAFETERIA	7,177	55,729	0	6,042	473,062	11.00
13.00	01300	NURSING ADMINISTRATION	75,816	38,318	0	4,154	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,068	250,290	0	27,134	0	14.00
15.00	01500	PHARMACY	84,289	97,019	0	10,518	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,011	60,629	0	6,573	0	16.00
17.00	01700	SOCIAL SERVICE	59,577	15,811	0	1,714	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	948,357	1,585,463	377,874	171,878	875,026	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,801	191,131	0	20,720	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,989	70,069	0	7,596	0	54.00
60.00	06000	LABORATORY	48,692	74,218	0	8,046	0	60.00
65.00	06500	RESPIRATORY THERAPY	153,305	77,452	0	8,397	0	65.00
66.00	06600	PHYSICAL THERAPY	110,880	140,563	0	15,238	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,825	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,574	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	55,583	33,287	0	3,609	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,405,214	3,111,376	377,874	321,356	1,348,088	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,545	19,763	0	2,143	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	241	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	194,920	0	21,131	0	194.02
194.03	07953	DISTRICT OFFICE	0	217,819	0	23,614	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	26,108	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0	194.11
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)	2,408,000	3,543,878	377,874	368,244	1,374,196	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part II Date/Time Prepared: 1/25/2017 12:13 pm
-------------------------------------	--	----------------------	---	---

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	735,244					11.00
13.00	01300	33,934	312,799				13.00
14.00	01400	15,082	0	1,209,568			14.00
15.00	01500	0	0	8,313	536,542		15.00
16.00	01600	32,049	0	1,075	0	394,903	16.00
17.00	01700	24,508	0	34	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	490,163	308,060	15,753	12,302	192,096	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,541	4,739	544	0	3,218	50.00
54.00	05400	7,541	0	360	82	9,548	54.00
60.00	06000	28,279	0	3,977	0	30,643	60.00
65.00	06500	94,262	0	2,941	0	49,761	65.00
66.00	06600	0	0	692	0	12,405	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	0	1,175,873	0	13,913	71.00
73.00	07300	0	0	0	524,158	75,490	73.00
74.00	07400	1,885	0	6	0	7,829	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		735,244	312,799	1,209,568	536,542	394,903	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		735,244	312,799	1,209,568	536,542	394,903	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part II Date/Time Prepared: 1/25/2017 12:13 pm
-------------------------------------	--	----------------------	---	---

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE	178,486			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	178,486	10,921,106	0	10,921,106	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	932,657	0	932,657	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	368,737	0	368,737	54.00
60.00	06000	LABORATORY	0	462,774	0	462,774	60.00
65.00	06500	RESPIRATORY THERAPY	0	710,765	0	710,765	65.00
66.00	06600	PHYSICAL THERAPY	0	767,165	0	767,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,319,611	0	1,319,611	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	725,222	0	725,222	73.00
74.00	07400	RENAL DIALYSIS	0	218,390	0	218,390	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	178,486	16,426,427	0	16,426,427	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	92,977	0	92,977	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	333	0	333	194.00
194.01	07951	IDLE SPACE	0	142,974	0	142,974	194.01
194.02	07952	REGIONAL OFFICE	0	891,914	0	891,914	194.02
194.03	07953	DISTRICT OFFICE	0	996,696	0	996,696	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	0	194.06
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	26,108	0	26,108	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	178,486	18,577,429	0	18,577,429	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet B-1

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET #1)	MVBLE EQUIP (SQUARE FEET #2)				
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	158,736				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		157,255			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,565	4,565	29,429,545		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,191	15,191	3,681,352	-25,312,505	5.00
7.00 00700	OPERATION OF PLANT	29,012	29,012	247,855	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,434	2,434	0	0	8.00
9.00 00900	HOUSEKEEPING	2,069	2,069	801,565	0	9.00
10.00 01000	DIETARY	8,397	8,397	860,139	0	10.00
11.00 01100	CAFETERIA	1,706	1,706	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,173	1,173	1,577,424	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,662	7,662	235,875	0	14.00
15.00 01500	PHARMACY	2,970	2,970	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,856	1,856	1,044,008	0	16.00
17.00 01700	SOCIAL SERVICE	484	484	1,253,327	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	48,535	48,535	15,267,772	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,851	5,851	298,183	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,145	2,145	261,503	0	54.00
60.00 06000	LABORATORY	2,272	2,272	658,871	0	60.00
65.00 06500	RESPIRATORY THERAPY	2,371	2,371	3,192,455	0	65.00
66.00 06600	PHYSICAL THERAPY	4,303	4,303	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
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	1,019	1,019	43,958	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	144,015	144,015	29,424,287	-25,312,505	64,753,687
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	605	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	5,258	0	194.00
194.01 07951	IDLE SPACE	1,481	0	0	-142,974	194.01
194.02 07952	REGIONAL OFFICE	5,967	5,967	0	-685,093	194.02
194.03 07953	DISTRICT OFFICE	6,668	6,668	0	-755,263	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
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)	15,324,214	2,630,532	5,465,567		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	96.538996	16.727812	0.185717		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			517,063		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.017570		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet B-1

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET #3)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET #4)	DIETARY (MEALS SERVED)	CAFETERIA (CAFETERIA FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	108,487				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,434	56,240			8.00
9.00	00900	HOUSEKEEPING	2,069	0	103,984		9.00
10.00	01000	DIETARY	8,397	0	8,397	206,175	10.00
11.00	01100	CAFETERIA	1,706	0	1,706	70,975	390
13.00	01300	NURSING ADMINISTRATION	1,173	0	1,173	0	18
14.00	01400	CENTRAL SERVICES & SUPPLY	7,662	0	7,662	0	8
15.00	01500	PHARMACY	2,970	0	2,970	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,856	0	1,856	0	17
17.00	01700	SOCIAL SERVICE	484	0	484	0	13
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	48,535	56,240	48,535	131,283	260
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,851	0	5,851	0	4
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,145	0	2,145	0	4
60.00	06000	LABORATORY	2,272	0	2,272	0	15
65.00	06500	RESPIRATORY THERAPY	2,371	0	2,371	0	50
66.00	06600	PHYSICAL THERAPY	4,303	0	4,303	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	1,019	0	1,019	0	1
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	95,247	56,240	90,744	202,258	390
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	605	0	605	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	5,967	0	5,967	0	0
194.03	07953	DISTRICT OFFICE	6,668	0	6,668	0	0
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	0	0
194.05	07955	REG NURSG OFFICE	0	0	0	0	0
194.06	07956	CONTACT CENTER	0	0	0	0	0
194.07	07957	CENTRALIZED ADMISSIONS DEPT	0	0	0	0	0
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	0
194.09	07958	VISITOR MEALS	0	0	0	3,917	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
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)	9,486,813	1,061,576	2,135,922	4,797,869	2,104,559
203.00		Unit cost multiplier (Wkst. B, Part I)	87.446542	18.875818	20.540872	23.270857	5,396.305128
204.00		Cost to be allocated (per Wkst. B, Part II)	3,543,878	377,874	368,244	1,374,196	735,244
205.00		Unit cost multiplier (Wkst. B, Part II)	32.666384	6.718954	3.541353	6.665192	1,885.241026

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet B-1
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		NURSING ADMINISTRATION (NURSING FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	264					13.00
14.00	01400	0	3,595,340				14.00
15.00	01500	0	24,710	3,460,600			15.00
16.00	01600	0	3,195	0	306,862,621		16.00
17.00	01700	0	102	0	0	56,240	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	260	46,823	79,346	149,282,012	56,240	30.00
31.00	03100	0	0	0	0	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4	1,616	0	2,500,135	0	50.00
54.00	05400	0	1,071	527	7,418,429	0	54.00
60.00	06000	0	11,820	0	23,809,414	0	60.00
65.00	06500	0	8,743	0	38,664,663	0	65.00
66.00	06600	0	2,058	0	9,638,577	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
71.00	07100	0	3,495,185	0	10,810,751	0	71.00
73.00	07300	0	0	3,380,727	58,655,803	0	73.00
74.00	07400	0	17	0	6,082,837	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
98.00	09850	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
118.00		264	3,595,340	3,460,600	306,862,621	56,240	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07959	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07962	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
200.00							200.00
201.00							201.00
202.00		3,061,897	2,557,631	3,493,569	2,765,505	2,352,706	202.00
203.00		11,598.094697	0.711374	1.009527	0.009012	41.833321	203.00
204.00		312,799	1,209,568	536,542	394,903	178,486	204.00
205.00		1,184.844697	0.336427	0.155043	0.001287	3.173649	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/25/2017 12:13 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		53,088,640	149,440	53,238,080	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		2,101,090	10,259	2,111,349	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,294,225	0	1,294,225	54.00
60.00	06000 LABORATORY		2,372,017	19,791	2,391,808	60.00
65.00	06500 RESPIRATORY THERAPY	0	6,619,366	0	6,619,366	65.00
66.00	06600 PHYSICAL THERAPY	0	4,703,702	0	4,703,702	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		7,443,695	0	7,443,695	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		8,642,280	0	8,642,280	73.00
74.00	07400 RENAL DIALYSIS		2,250,977	0	2,250,977	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
200.00	Subtotal (see instructions)		88,515,992	179,490	88,695,482	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		88,515,992	179,490	88,695,482	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet C
Part I
Date/Time Prepared:
1/25/2017 12:13 pm

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	149,282,012		149,282,012		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,500,135	0	2,500,135	0.840391	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,418,429	0	7,418,429	0.174461	54.00
60.00	06000	LABORATORY	23,809,414	0	23,809,414	0.099625	60.00
65.00	06500	RESPIRATORY THERAPY	38,664,663	0	38,664,663	0.171199	65.00
66.00	06600	PHYSICAL THERAPY	9,638,577	0	9,638,577	0.488008	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,810,751	0	10,810,751	0.688546	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,655,803	0	58,655,803	0.147339	73.00
74.00	07400	RENAL DIALYSIS	6,082,837	0	6,082,837	0.370054	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
200.00		Subtotal (see instructions)	306,862,621	0	306,862,621		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	306,862,621	0	306,862,621		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/25/2017 12:13 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.844494		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.174461		54.00
60.00	06000 LABORATORY	0.100456		60.00
65.00	06500 RESPIRATORY THERAPY	0.171199		65.00
66.00	06600 PHYSICAL THERAPY	0.488008		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.688546		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147339		73.00
74.00	07400 RENAL DIALYSIS	0.370054		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
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: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet C
Part I
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	53,088,640		53,088,640	149,440	53,238,080	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,101,090		2,101,090	10,259	2,111,349	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,294,225		1,294,225	0	1,294,225	54.00
60.00	06000 LABORATORY	2,372,017		2,372,017	19,791	2,391,808	60.00
65.00	06500 RESPIRATORY THERAPY	6,619,366	0	6,619,366	0	6,619,366	65.00
66.00	06600 PHYSICAL THERAPY	4,703,702	0	4,703,702	0	4,703,702	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,443,695		7,443,695	0	7,443,695	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,642,280		8,642,280	0	8,642,280	73.00
74.00	07400 RENAL DIALYSIS	2,250,977		2,250,977	0	2,250,977	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	88,515,992	0	88,515,992	179,490	88,695,482	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	88,515,992	0	88,515,992	179,490	88,695,482	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet C
Part I
Date/Time Prepared:
1/25/2017 12:13 pm

		Title XIX			Hospital	Cost		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	149,282,012		149,282,012			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,500,135	0	2,500,135	0.840391	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,418,429	0	7,418,429	0.174461	0.000000	54.00
60.00	06000	LABORATORY	23,809,414	0	23,809,414	0.099625	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	38,664,663	0	38,664,663	0.171199	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,638,577	0	9,638,577	0.488008	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,810,751	0	10,810,751	0.688546	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,655,803	0	58,655,803	0.147339	0.000000	73.00
74.00	07400	RENAL DIALYSIS	6,082,837	0	6,082,837	0.370054	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
200.00		Subtotal (see instructions)	306,862,621	0	306,862,621			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	306,862,621	0	306,862,621			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/25/2017 12:13 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet D Part I Date/Time Prepared: 1/25/2017 12:13 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,921,106	0	10,921,106	56,240	194.19	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (Lines 30-199)	10,921,106		10,921,106	56,240		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	17,969	3,489,400				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	17,969	3,489,400				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part II Date/Time Prepared: 1/25/2017 12:13 pm
		Title XVIII	Hospital	PPS

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	932,657	2,500,135	0.373043	1,063,791	396,840	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	368,737	7,418,429	0.049706	2,645,420	131,493	54.00
60.00	06000	LABORATORY	462,774	23,809,414	0.019437	9,180,996	178,451	60.00
65.00	06500	RESPIRATORY THERAPY	710,765	38,664,663	0.018383	13,783,970	253,391	65.00
66.00	06600	PHYSICAL THERAPY	767,165	9,638,577	0.079593	3,583,303	285,206	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,319,611	10,810,751	0.122065	4,280,778	522,533	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	725,222	58,655,803	0.012364	20,149,832	249,133	73.00
74.00	07400	RENAL DIALYSIS	218,390	6,082,837	0.035903	2,755,760	98,940	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (Lines 50-199)	5,505,321	157,580,609		57,443,850	2,115,987	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet D Part III Date/Time Prepared: 1/25/2017 12:13 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	56,240	0.00	17,969	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
200.00		Total (lines 30-199)	56,240		17,969	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet D
Part IV
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet D
Part IV
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	2,500,135	0.000000	0.000000	1,063,791	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,418,429	0.000000	0.000000	2,645,420	54.00
60.00	06000 LABORATORY	0	23,809,414	0.000000	0.000000	9,180,996	60.00
65.00	06500 RESPIRATORY THERAPY	0	38,664,663	0.000000	0.000000	13,783,970	65.00
66.00	06600 PHYSICAL THERAPY	0	9,638,577	0.000000	0.000000	3,583,303	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,810,751	0.000000	0.000000	4,280,778	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	58,655,803	0.000000	0.000000	20,149,832	73.00
74.00	07400 RENAL DIALYSIS	0	6,082,837	0.000000	0.000000	2,755,760	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (Lines 50-199)	0	157,580,609			57,443,850	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/25/2017 12:13 pm
--	----------------------	---	---

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	0	0		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part V Date/Time Prepared: 1/25/2017 12:13 pm
--	----------------------	---	--

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	0.840391	0	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.174461	0	471,710	0	0
60.00	06000 LABORATORY	0.099625	0	9,306	0	0
65.00	06500 RESPIRATORY THERAPY	0.171199	0	308,518	0	0
66.00	06600 PHYSICAL THERAPY	0.488008	0	0	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.688546	0	70,200	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147339	0	0	0	0
74.00	07400 RENAL DIALYSIS	0.370054	0	622,965	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	0
91.00	09100 EMERGENCY	0.000000	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.000000	0	0	0	0
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0
200.00	Subtotal (see instructions)		0	1,482,699	0	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00	Net Charges (line 200 +/- line 201)		0	1,482,699	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet D
Part V
Date/Time Prepared:
1/25/2017 12:13 pm

Title XVIII

Hospital

PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	82,295	0	54.00
60.00	06000 LABORATORY	927	0	60.00
65.00	06500 RESPIRATORY THERAPY	52,818	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48,336	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	230,531	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	414,907	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	414,907	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/25/2017 12:13 pm
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		56,240	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		56,240	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)		56,240	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		17,969	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		53,238,080	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		53,238,080	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)		53,238,080	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)		946.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		17,009,815	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)		17,009,815	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 1/25/2017 12:13 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					13,326,806		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					30,336,621		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)					3,489,400		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,115,987		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					5,605,387		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					24,731,234		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet D-1 Date/Time Prepared: 1/25/2017 12:13 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	10,921,106	53,238,080	0.205137	0	0	90.00
91.00	Nursing School cost	0	53,238,080	0.000000	0	0	91.00
92.00	Allied health cost	0	53,238,080	0.000000	0	0	92.00
93.00	All other Medical Education	0	53,238,080	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 1/25/2017 12:13 pm
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)		56,240	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		56,240	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)		56,240	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		13,447	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		53,088,640	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		53,088,640	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)		53,088,640	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)		943.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,693,565	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)		12,693,565	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet D-1	
Date/Time Prepared: 1/25/2017 12:13 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,825,313		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					19,518,878		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet D-1 Date/Time Prepared: 1/25/2017 12:13 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	10,921,106	53,088,640	0.205715	0	0	90.00
91.00	Nursing School cost	0	53,088,640	0.000000	0	0	91.00
92.00	Allied health cost	0	53,088,640	0.000000	0	0	92.00
93.00	All other Medical Education	0	53,088,640	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet D-2

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V															
	1.00	2.00	3.00	4.00	5.00															
PART I - NOT IN APPROVED TEACHING PROGRAM																				
Hospital Inpatient Routine Services:																				
1.00 Total cost of services rendered	0.00	0				1.00														
2.00 ADULTS & PEDIATRICS	0.00	0	56,240	0.00	0	2.00														
3.00 INTENSIVE CARE UNIT	0.00	0	0	0.00	0	3.00														
4.00 CORONARY CARE UNIT						4.00														
5.00 BURN INTENSIVE CARE UNIT						5.00														
6.00 SURGICAL INTENSIVE CARE UNIT						6.00														
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00														
8.00 NURSERY						8.00														
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00														
10.00 SUBPROVIDER - IPF						10.00														
11.00 SUBPROVIDER - IRF						11.00														
12.00 SUBPROVIDER						12.00														
13.00 SKILLED NURSING FACILITY	0.00	0	0	0.00	0	13.00														
14.00 NURSING FACILITY						14.00														
15.00 OTHER LONG TERM CARE						15.00														
16.00 HOME HEALTH AGENCY						16.00														
17.00 CMHC						17.00														
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00														
19.00 HOSPICE						19.00														
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description			Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00	
Cost Center Description			Total Charges (from Worksheet C. Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V															
	1.00	2.00	3.00	4.00	5.00															
Hospital Outpatient Services:																				
21.00 RURAL HEALTH CLINIC						21.00														
22.00 FEDERALLY QUALIFIED HEALTH CENTER						22.00														
23.00 CLINIC	0.00	0	0	0.000000	0	23.00														
24.00 EMERGENCY	0.00	0	0	0.000000	0	24.00														
25.00 OBSERVATION BEDS (NON-DISTINCT PART)						25.00														
26.00 OTHER OUTPATIENT SERVICE COST CENTER						26.00														
27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00														
28.00 Total (sum of lines 20 and 27)	0.00	0				28.00														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td> </tr> </thead> </table>							Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)			1.00	2.00	3.00	4.00	5.00	
Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)															
	1.00	2.00	3.00	4.00	5.00															
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)																				
Hospital Inpatient Routine Services:																				
29.00 ADULTS & PEDIATRICS	0	0	0	56,240	0.00	29.00														
30.00 Swing Bed - SNF				0	0.00	30.00														
31.00 Swing Bed - NF				0		31.00														
32.00 INTENSIVE CARE UNIT	0			0	0.00	32.00														
33.00 CORONARY CARE UNIT						33.00														
34.00 BURN INTENSIVE CARE UNIT						34.00														
35.00 SURGICAL INTENSIVE CARE UNIT						35.00														
36.00 OTHER SPECIAL CARE (SPECIFY)						36.00														
37.00 Subtotal (sum of lines 29, and 32 through 36)	0		0			37.00														
38.00 SUBPROVIDER - IPF						38.00														
39.00 SUBPROVIDER - IRF						39.00														
40.00 SUBPROVIDER						40.00														
41.00 SKILLED NURSING FACILITY	0			0	0.00	41.00														
42.00 Total (sum of lines 37 through 41)	0			0		42.00														

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet D-2

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description	Not In Approved Teaching Program		In Approved Teaching Program	
	(from Part I:)	Amount	(from Part II, col. 7, -)	
	1.00	2.00	3.00	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
Hospital				
43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF				47.00
48.00 SUBPROVIDER				48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0 col. 9, line 41.00	49.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet D-2

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered					1.00
Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	17,969	13,447	0	0	0
3.00	INTENSIVE CARE UNIT	0	0	0	0	0
4.00	CORONARY CARE UNIT					
5.00	BURN INTENSIVE CARE UNIT					
6.00	SURGICAL INTENSIVE CARE UNIT					
7.00	OTHER SPECIAL CARE (SPECIFY)					
8.00	NURSERY					
9.00	Subtotal (sum of lines 2 through 8)			0	0	0
10.00	SUBPROVIDER - IPF					
11.00	SUBPROVIDER - IRF					
12.00	SUBPROVIDER					
13.00	SKILLED NURSING FACILITY	0	0	0	0	0
14.00	NURSING FACILITY					
15.00	OTHER LONG TERM CARE					
16.00	HOME HEALTH AGENCY					
17.00	CMHC					
18.00	AMBULATORY SURGICAL CENTER (D.P.)					
19.00	HOSPICE					
20.00	Subtotal (sum of lines 9 through 19)					
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC					
22.00	FEDERALLY QUALIFIED HEALTH CENTER					
23.00	CLINIC	0	0	0	0	0
24.00	EMERGENCY	0	0	0	0	0
25.00	OBSERVATION BEDS (NON-DISTINCT PART)					
26.00	OTHER OUTPATIENT SERVICE COST CENTER					
27.00	Subtotal (sum of lines 21 through 26)			0	0	0
28.00	Total (sum of lines 20 and 27)					
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0		29.00
30.00	Swing Bed - SNF	0	0			30.00
31.00	Swing Bed - NF					31.00
32.00	INTENSIVE CARE UNIT	0	0	0		32.00
33.00	CORONARY CARE UNIT					33.00
34.00	BURN INTENSIVE CARE UNIT					34.00
35.00	SURGICAL INTENSIVE CARE UNIT					35.00
36.00	OTHER SPECIAL CARE (SPECIFY)					36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)		0	0		37.00
38.00	SUBPROVIDER - IPF					38.00
39.00	SUBPROVIDER - IRF					39.00
40.00	SUBPROVIDER					40.00
41.00	SKILLED NURSING FACILITY	0	0	0		41.00
42.00	Total (sum of lines 37 through 41)		0	0		42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet D-2

Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs			
	Amount	(to Wkst. E, Part B -)	(col. 2 + col. 4)		
	4.00	5.00	6.00		
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)					
Hospital					
43.00	Inpatient	0		0	43.00
44.00	Outpatient				44.00
45.00	Total Hospital (sum of lines 43 and 44)	0	line 22	0	45.00
46.00	SUBPROVIDER - IPF				46.00
47.00	SUBPROVIDER - IRF				47.00
48.00	SUBPROVIDER				48.00
49.00	SKILLED NURSING FACILITY	0	line 22	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet D-3 Date/Time Prepared: 1/25/2017 12:13 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		48,772,849		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.844494	1,063,791	898,365	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.174461	2,645,420	461,523	54.00
60.00	06000 LABORATORY	0.100456	9,180,996	922,286	60.00
65.00	06500 RESPIRATORY THERAPY	0.171199	13,783,970	2,359,802	65.00
66.00	06600 PHYSICAL THERAPY	0.488008	3,583,303	1,748,681	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.688546	4,280,778	2,947,513	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147339	20,149,832	2,968,856	73.00
74.00	07400 RENAL DIALYSIS	0.370054	2,755,760	1,019,780	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		57,443,850	13,326,806	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)		57,443,850		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet D-3 Date/Time Prepared: 1/25/2017 12:13 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		34,451,875		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.840391	463,074	389,163	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.174461	937,712	163,594	54.00
60.00	06000 LABORATORY	0.099625	3,277,141	326,485	60.00
65.00	06500 RESPIRATORY THERAPY	0.171199	8,138,838	1,393,361	65.00
66.00	06600 PHYSICAL THERAPY	0.488008	1,707,179	833,117	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.688546	2,598,747	1,789,357	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.147339	12,009,922	1,769,530	73.00
74.00	07400 RENAL DIALYSIS	0.370054	434,276	160,706	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		29,566,889	6,825,313	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)		29,566,889		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part B Date/Time Prepared: 1/25/2017 12:13 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		414,907	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		414,907	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,482,699	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)		1,482,699	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)		1,482,699	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,067,792	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)		414,907	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)		296,540	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		118,367	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)		118,367	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		118,367	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		118,367	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)		118,367	40.00
40.01	Sequestration adjustment (see instructions)		2,367	40.01
41.00	Interim payments		109,702	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		6,298	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: 142008		Period: From 09/01/2015 To 08/31/2016		Worksheet E-1 Part I Date/Time Prepared: 1/25/2017 12:13 pm	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		26,135,375		109,702	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	11/23/2016	449,900		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)		449,900		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)		26,585,275		109,702	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		190,853		6,298	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		26,776,128		116,000	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		Provi der CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part IV Date/Time Prepared: 1/25/2017 12: 13 pm
		Title XVII I	Hospi tal	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		26,848,022	1.00
2.00	Outlier Payments		2,366,256	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		29,214,278	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospi tal (see instructions)		0	6.00
7.00	Subtotal (see instructions)		29,214,278	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		29,214,278	9.00
10.00	Deductibles		66,556	10.00
11.00	Subtotal (line 9 minus line 10)		29,147,722	11.00
12.00	Coinurance		2,707,229	12.00
13.00	Subtotal (line 11 minus line 12)		26,440,493	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,357,057	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		882,087	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,184,600	16.00
17.00	Subtotal (sum of lines 13 and 15)		27,322,580	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		27,322,580	22.00
22.01	Sequestration adjustment (see instructions)		546,452	22.01
23.00	Interim payments		26,585,275	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)		190,853	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142008	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 1/25/2017 12:13 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		19,518,878		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		19,518,878	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		19,518,878	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		34,451,875		8.00
9.00	Ancillary service charges		29,566,889	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		64,018,764	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		64,018,764	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		44,499,886	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		19,518,878	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		19,518,878	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		19,518,878	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		19,518,878	0	36.00
37.00	OTHER ADJUSTMENTS		0		37.00
37.01	OTHER ADJUSTMENTS		0		37.01
38.00	Subtotal (line 36 ± line 37)		19,518,878	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		19,518,878	0	40.00
41.00	Interim payments		13,857,729		41.00
42.00	Balance due provider/program (line 40 minus line 41)		5,661,149		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

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

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet G

Date/Time Prepared:
1/25/2017 12:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-150,519	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	30,792,094	0	0	0	4.00
5.00	Other receivable	62,671	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,676,741	0	0	0	6.00
7.00	Inventory	609,640	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,637,145	0	0	0	11.00
FIXED ASSETS						
12.00	Land	675,156	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	31,090	0	0	0	15.00
16.00	Accumulated depreciation	-31,090	0	0	0	16.00
17.00	Leasehold improvements	35,145,228	0	0	0	17.00
18.00	Accumulated depreciation	-31,877,671	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	16,054,227	0	0	0	23.00
24.00	Accumulated depreciation	-12,739,061	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)	7,257,879	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	211,265	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	211,265	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,106,289	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,013,376	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,226,745	0	0	0	38.00
39.00	Payroll taxes payable	5,852	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	3,622,657	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,868,630	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-67,449,262	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-67,449,262	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-59,580,632	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	89,686,921				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	89,686,921	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,106,289	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet G-1

Date/Time Prepared:
1/25/2017 12:13 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		90,884,800		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,197,882			2.00
3.00	Total (sum of line 1 and line 2)		89,686,918		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	3		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		3		0	10.00
11.00	Subtotal (line 3 plus line 10)		89,686,921		0	11.00
12.00	Deductions (debit adjustments)	0		0		12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		89,686,921		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)		0			4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING		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)		0			12.00
13.00	INTERCOMPANY TRANSFERS\ROUNDING		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: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/25/2017 12:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	149,282,012		149,282,012	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	149,282,012		149,282,012	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	149,282,012		149,282,012	17.00
18.00	Ancillary services	157,580,609	0	157,580,609	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	306,862,621	0	306,862,621	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		91,153,666		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)		91,153,666		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142008

Period:
From 09/01/2015
To 08/31/2016

Worksheet G-3

Date/Time Prepared:
1/25/2017 12:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	306,862,621	1.00
2.00	Less contractual allowances and discounts on patients' accounts	217,201,313	2.00
3.00	Net patient revenues (line 1 minus line 2)	89,661,308	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	91,153,666	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,492,358	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	10,080	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	124,570	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6,499	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	153,327	24.00
25.00	Total other income (sum of lines 6-24)	294,476	25.00
26.00	Total (line 5 plus line 25)	-1,197,882	26.00
27.00	OTHER EXPENSES	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)	-1,197,882	29.00