

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: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet S Parts I-III Date/Time Prepared: 1/27/2017 2:38 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/27/2017 Time: 2:38 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital Chicago Central (142009) 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	-53,533	25,229	0	2,026,930	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	-53,533	25,229	0	2,026,930	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet S-2 Part I Date/Time Prepared: 1/24/2017 2:51 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 4058 West Melrose Street		PO Box:				1.00			
2.00	City: Chicago		State: IL		Zip Code: 60641		County: Cook			
		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		Kindred Hospital Chicago Central		142009	16974	2	07/01/1994	N P O	
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							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: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/24/2017 2:51 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

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
					1.00		
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
	1.00	2.00	3.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 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		
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)	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
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		
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	
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		
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	
				1.00		
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			Y		
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		
85.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		
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		
				V	XIX	
				1.00	2.00	
90.00	Title V and XIX Services 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	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	
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		
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	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	

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		V 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	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:	120,251	0	1,007,190		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: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet S-2 Part I Date/Time Prepared: 1/24/2017 2:51 pm	
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	189003				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: KINDRED HEALTHCARE OPERATING INC.	Contractor's Name: WISCONSIN PHYSICIANS SERVICES		Contractor's Number: 05901			141.00
142.00	Street: 680 SOUTH FOURTH AVENUE	PO Box:					142.00
143.00	City: LOUISVILLE	State: KY		Zip Code: 40202			143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y					145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
				Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC	N	N	N	N		161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N				165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
166.01							0.00
166.02							0.00
166.03							0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		N				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/24/2017 2:51 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)			171.00
			N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet S-2 Part II Date/Time Prepared: 1/24/2017 2:51 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				
		1.00	2.00				
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				
		1.00	2.00				
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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/31/2016	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: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part II Date/Time Prepared: 1/24/2017 2:51 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 142009

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

Worksheet S-2
Part II
Date/Time Prepared:
1/24/2017 2:51 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 142009

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

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2017 2:51 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	187	68,442	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)		187	68,442	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)		187	68,442	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)		187				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: 142009

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

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2017 2:51 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)	13,409	6,622	34,277			1.00
2.00 HMO and other (see instructions)	1,956	8,225				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)	13,409	6,622	34,277			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)	13,409	6,622	34,277	0.00	317.60	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	317.60	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	746					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 142009

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

Worksheet S-3
Part I
Date/Time Prepared:
1/24/2017 2:51 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	510	208	1,157	1.00
2.00 HMO and other (see instructions)			67	304		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	510	208	1,157	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: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet S-3 Part II Date/Time Prepared: 1/24/2017 2:51 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	18,577,335	-16,975	18,560,360	661,942.50	28.04	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	2,733	2,733	56.00	48.80	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		3,738,684	0	3,738,684	64,611.00	57.86	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		1,743,178	0	1,743,178	22,205.00	78.50	13.00
14.00	Home office salaries & wage-related costs		2,547,455	0	2,547,455	41,761.56	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)		2,789,847	0	2,789,847			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		410	0	410			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	136,252	0	136,252	2,729.34	49.92	26.00
27.00	Administrative & General	5.00	2,599,757	-16,975	2,582,782	66,050.41	39.10	27.00
28.00	Administrative & General under contract (see inst.)		28,680	0	28,680	640.00	44.81	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	179,907	0	179,907	12,788.00	14.07	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	674,399	0	674,399	51,649.00	13.06	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	582,602	0	582,602	36,955.00	15.77	34.00
35.00	Dietary under contract (see instructions)		13,295	0	13,295	683.00	19.47	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	1,308,965	0	1,308,965	30,477.00	42.95	38.00
39.00	Central Services and Supply	14.00	123,598	0	123,598	9,812.00	12.60	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 142009

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

Worksheet S-3
Part II
Date/Time Prepared:
1/24/2017 2:51 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	16.00 707,930	0	707,930	23,510.00	30.11	41.00
42.00	Social Service	17.00 653,714	-2,733	650,981	13,402.00	48.57	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 Part III Date/Time Prepared: 1/24/2017 2:51 pm
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	Worksheet A Line Number	Amount Reported	Recl assi fi cation 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)	18,619,310	-16,975	18,602,335	663,265.50	28.05	1.00
2.00	Excluded area salaries (see instructions)	0	2,733	2,733	56.00	48.80	2.00
3.00	Subtotal salaries (line 1 minus line 2)	18,619,310	-19,708	18,599,602	663,209.50	28.04	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,029,317	0	8,029,317	128,577.56	62.45	4.00
5.00	Subtotal wage-related costs (see inst.)	2,789,847	0	2,789,847	0.00	15.00	5.00
6.00	Total (sum of lines 3 thru 5)	29,438,474	-19,708	29,418,766	791,787.06	37.15	6.00
7.00	Total overhead cost (see instructions)	7,009,099	-19,708	6,989,391	248,695.75	28.10	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 1/24/2017 2:51 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)		765,694	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		-9,805	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		11,507	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)		60,496	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		439,798	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		1,321,889	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		191,317	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		8,950	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		2,789,846	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: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet A	
Date/Time Prepared: 1/24/2017 2:51 pm							
Cost Center	Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		5,868,801	5,868,801	472,947	6,341,748	1.00
2.00	00200		1,326,170	1,326,170	444,824	1,770,994	2.00
3.00	00300		917,771	917,771	-917,771	0	3.00
4.00	00400	136,252	3,009,175	3,145,427	0	3,145,427	4.00
5.00	00500	2,599,757	7,189,126	9,788,883	0	9,788,883	5.00
7.00	00700	179,907	3,062,730	3,242,637	0	3,242,637	7.00
8.00	00800	0	268,942	268,942	0	268,942	8.00
9.00	00900	674,399	96,964	771,363	0	771,363	9.00
10.00	01000	582,602	547,516	1,130,118	0	1,130,118	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,308,965	39,781	1,348,746	0	1,348,746	13.00
14.00	01400	123,598	31,935	155,533	0	155,533	14.00
15.00	01500	0	1,186,632	1,186,632	0	1,186,632	15.00
16.00	01600	707,930	174,735	882,665	0	882,665	16.00
17.00	01700	653,714	67,445	721,159	-3,015	718,144	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	7,186,749	2,684,269	9,871,018	1,544,771	11,415,789	30.00
31.00	03100	1,508,514	36,257	1,544,771	-1,544,771	0	31.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	396,637	598,825	995,462	0	995,462	50.00
54.00	05400	186,491	590,496	776,987	0	776,987	54.00
60.00	06000	164,884	937,579	1,102,463	0	1,102,463	60.00
65.00	06500	2,166,750	139,585	2,306,335	0	2,306,335	65.00
66.00	06600	186	1,784,129	1,784,315	0	1,784,315	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	2,021,749	2,021,749	0	2,021,749	71.00
73.00	07300	0	2,336,282	2,336,282	0	2,336,282	73.00
74.00	07400	0	955,457	955,457	0	955,457	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		18,577,335	35,872,351	54,449,686	-3,015	54,446,671	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	3,015	3,015	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		18,577,335	35,872,351	54,449,686	0	54,449,686	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 142009

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

Worksheet A
Date/Time Prepared:
1/24/2017 2:51 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	-683,448	5,658,300	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	83,910	1,854,904	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-13,016	3,132,411	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	120,679	9,909,562	5.00
7.00	00700	OPERATION OF PLANT	-10,867	3,231,770	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	268,942	8.00
9.00	00900	HOUSEKEEPING	0	771,363	9.00
10.00	01000	DIETARY	-61,038	1,069,080	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,348,746	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	155,533	14.00
15.00	01500	PHARMACY	0	1,186,632	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,116	880,549	16.00
17.00	01700	SOCIAL SERVICE	0	718,144	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-52,174	11,363,615	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	0	995,462	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	776,987	54.00
60.00	06000	LABORATORY	0	1,102,463	60.00
65.00	06500	RESPIRATORY THERAPY	5,793	2,312,128	65.00
66.00	06600	PHYSICAL THERAPY	-137,003	1,647,312	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	2,021,749	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,336,282	73.00
74.00	07400	RENAL DIALYSIS	0	955,457	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)	-749,280	53,697,391	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	3,015	194.00
194.01	07951	IDLE SPACE	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	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)	-749,280	53,700,406	200.00

RECLASSIFICATIONS

Provider CCN: 142009

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

Worksheet A-6

Date/Time Prepared:
1/24/2017 2:51 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	2,733	282	1.00
	LIASON					
	TOTALS			2,733	282	
	C - RECLASS ICU EXPENSE					
1.00	ADULTS & PEDIATRICS		30.00	1,508,514	36,257	1.00
	TOTALS			1,508,514	36,257	
	F - RECLASS VAN SERVICE					
1.00	ADMINISTRATIVE & GENERAL		5.00	0	16,975	1.00
	TOTALS			0	16,975	
500.00	Grand Total: Increases			1,511,247	53,514	500.00

RECLASSIFICATIONS

Provider CCN: 142009

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

Worksheet A-6
Date/Time Prepared:
1/24/2017 2:51 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	2,733	282	0		1.00
	TOTALS		2,733	282			
C - RECLASS ICU EXPENSE							
1.00	INTENSIVE CARE UNIT	31.00	1,508,514	36,257	0		1.00
	TOTALS		1,508,514	36,257			
F - RECLASS VAN SERVICE							
1.00	ADMINISTRATIVE & GENERAL	5.00	16,975	0	0		1.00
	TOTALS		16,975	0			
500.00	Grand Total: Decreases		1,528,222	36,539			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142009

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

Worksheet A-7
Part I
Date/Time Prepared:
1/24/2017 2:51 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	69,408	0	0	0	3.00
4.00	Building Improvements	10,400,201	823,152	0	823,152	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	10,103,049	518,210	0	518,210	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,572,658	1,341,362	0	1,341,362	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,572,658	1,341,362	0	1,341,362	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	69,408	0			3.00
4.00	Building Improvements	11,223,353	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	10,621,259	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	21,914,020	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	21,914,020	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142009

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

Worksheet A-7
Part II
Date/Time Prepared:
1/24/2017 2:51 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,374,070	4,494,731	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	306,981	1,019,189	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,681,051	5,513,920	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	5,868,801				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,326,170				2.00
3.00	Total (sum of lines 1-2)	0	7,194,971				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 142009

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

Worksheet A-7
Part III
Date/Time Prepared:
1/24/2017 2:51 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	11,292,761	0	11,292,761	0.515321	54,634	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,621,259	0	10,621,259	0.484679	51,385	2.00
3.00	Total (sum of lines 1-2)	21,914,020	0	21,914,020	1.000000	106,019	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	418,313	0	472,947	727,380	4,494,731	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	393,439	0	444,824	390,891	1,019,189	2.00
3.00	Total (sum of lines 1-2)	811,752	0	917,771	1,118,271	5,513,920	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	17,876	418,313	0	5,658,300	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	51,385	393,439	0	1,854,904	2.00
3.00	Total (sum of lines 1-2)	0	69,261	811,752	0	7,513,204	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 142009

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

Worksheet A-8

Date/Time Prepared:
1/24/2017 2:51 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-9,222		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	-50,582		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-4,771		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	-46,382				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,027,357				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-61,038		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	-2,116		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	-93,547		ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 142009

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

Worksheet A-8

Date/Time Prepared:
1/24/2017 2:51 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
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	81,456	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06		0		0.00	0	33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	-27,216	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICARE BAD DEBT - PART A	-1,326,854	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09		0		0.00	0	33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-148,931	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	-40	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	-622	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER OPERATING - MARKETING	-161,090	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	OTHER OPERATING - INTEREST	-999	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	OTHER OPERATING - CASH OVER SHORT	-18	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	-1,960	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	-18,665	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24		0		0.00	0	33.24
33.25	OTHER OPERATING - PENALTIES OTHER	-500	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.26		0		0.00	0	33.26
33.27		0		0.00	0	33.27
33.28	AGGREGATE CAPITAL EROSION	-112,458	ADMINISTRATIVE & GENERAL	5.00	0	33.28
33.29	CABLE TV AND SATELLITE	-34,942	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	101,663	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	EMP BEN - ADMISSION BONUS	-9,446	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	MALPRACTICE TAIL LIABILITY	-104,275	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	-1,132	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	-86,274	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	DISTRICT OFC SALES AND MKT BENEFITS	-10,266	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	-36,758	CAP REL COSTS-BLDG & FIXT	1.00	12	33.45
34.00	MEDICARE VS BOOK BLDG	-675,352	CAP REL COSTS-BLDG & FIXT	1.00	9	34.00
34.01	MEDICARE VS BOOK MOV EQUIP	29,895	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
34.02		0		0.00	0	34.02
34.03	ASSET ADD-ON BLDG	28,662	CAP REL COSTS-BLDG & FIXT	1.00	9	34.03
34.04	ASSET ADD-ON MOV EQUIP	59,653	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	-17,602	ADMINISTRATIVE & GENERAL	5.00	0	34.08
34.09	NON ALLOWABLE DUES AND SUBSCRIPTIONS	-3,450	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	-5,638	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.13
34.14		0		0.00	0	34.14

ADJUSTMENTS TO EXPENSES

Provider CCN: 142009

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

Worksheet A-8

Date/Time Prepared:
1/24/2017 2:51 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
34.15		0			0.00	0	34.15
34.16		0			0.00	0	34.16
34.17		0			0.00	0	34.17
34.18		0			0.00	0	34.18
34.19		0			0.00	0	34.19
34.20		0			0.00	0	34.20
34.21		0			0.00	0	34.21
34.22		0			0.00	0	34.22
34.23		0			0.00	0	34.23
34.24		0			0.00	0	34.24
34.25	VAN SERVICE VEHICLE MAINTENANCE	A	-6,096	OPERATION OF PLANT	7.00	0	34.25
34.26	VAN SERVICE EE BENEFITS	A	-2,750	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.26
34.27	VAN SERVICE SALARY	A	-16,975	ADMINISTRATIVE & GENERAL	5.00	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			0		0.00	0	35.06
35.07			0		0.00	0	35.07
35.08			0		0.00	0	35.08
35.09			0		0.00	0	35.09
35.10			0		0.00	0	35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	-11,855	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			0		0.00	0	35.14
35.15			0		0.00	0	35.15
35.16			0		0.00	0	35.16
35.17	PHYSICIAN FEE ADJUSTMENT	A	11,856	RESPIRATORY THERAPY	65.00	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.)		-749,280				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: 142009
 Period: From 09/01/2015 To 08/31/2016
 Worksheet A-8-1
 Date/Time Prepared: 1/24/2017 2:51 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	3,980,399	1,816,039 1.00
2.00	0.00			0	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	401,667	401,667 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	1,125,395	1,125,395 4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	1,644,700	1,781,703 4.01
4.20	50.00	OPERATING ROOM	Hospital Related services	397,567	397,567 4.20
4.21	54.00	RADIOLOGY-DIAGNOSTIC	Hospital Related services	417,045	417,045 4.21
4.22	60.00	LABORATORY	Hospital Related services	666,037	666,037 4.22
5.00	0			8,632,810	6,605,453 5.00

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

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

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested 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	B	KH01	100.00	KH - Chicago N.	100.00	10.00
10.01	B	KH01	100.00	KH - Chicago N.	100.00	10.01
10.02	B	KH01	100.00	KH - Chicago N.	100.00	10.02
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: 142009

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

Worksheet A-8-1

Date/Time Prepared:
1/24/2017 2:51 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	2,164,360	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-137,003	0		4.01
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
5.00	2,027,357			5.00

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

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

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

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

6.00	Home Office Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00	Therapy Svcs		9.00
10.00	OR		10.00
10.01	Radiology		10.01
10.02	Lab/Blood Bank		10.02
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: 142009

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

Worksheet A-8-2

Date/Time Prepared:
1/24/2017 2:51 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	667,435	0	667,435	177,200	8,782	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	DR. C	15,708	15,708	0	177,200	0	3.00
4.00	30.00	DR. D	3,675	0	3,675	177,200	35	4.00
5.00	30.00	DR. E	968,761	0	968,761	177,200	12,747	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	65.00	DR. G	11,856	0	11,856	177,200	68	7.00
8.00	30.00	DR. H	15,708	15,708	0	177,200	0	8.00
9.00	30.00	DR. I	13,568	0	13,568	177,200	101	9.00
10.00	30.00	DR. J	6,688	0	6,688	177,200	43	10.00
11.00	30.00	DR. K	221	221	0	177,200	0	11.00
200.00			1,703,620	31,637	1,671,983		21,776	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	748,159	37,408	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	30.00	DR. C	0	0	0	0	0	3.00
4.00	30.00	DR. D	2,982	149	0	0	0	4.00
5.00	30.00	DR. E	1,085,946	54,297	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	65.00	DR. G	5,793	290	0	0	0	7.00
8.00	30.00	DR. H	0	0	0	0	0	8.00
9.00	30.00	DR. I	8,604	430	0	0	0	9.00
10.00	30.00	DR. J	3,663	183	0	0	0	10.00
11.00	30.00	DR. K	0	0	0	0	0	11.00
200.00			1,855,147	92,757	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	748,159	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	30.00	DR. C	0	0	0	15,708		3.00
4.00	30.00	DR. D	0	2,982	693	693		4.00
5.00	30.00	DR. E	0	1,085,946	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	65.00	DR. G	0	5,793	6,063	6,063		7.00
8.00	30.00	DR. H	0	0	0	15,708		8.00
9.00	30.00	DR. I	0	8,604	4,964	4,964		9.00
10.00	30.00	DR. J	0	3,663	3,025	3,025		10.00
11.00	30.00	DR. K	0	0	0	221		11.00
200.00			0	1,855,147	14,745	46,382		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142009

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

Worksheet B
Part I
Date/Time Prepared:
1/24/2017 2:51 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,658,300	5,658,300			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,854,904		1,854,904		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,132,411	0	0	3,132,411	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,909,562	583,380	209,174	439,117	5.00
7.00 00700	OPERATION OF PLANT	3,231,770	870,948	312,284	30,587	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	268,942	32,701	11,725	0	8.00
9.00 00900	HOUSEKEEPING	771,363	125,244	44,907	114,659	9.00
10.00 01000	DIETARY	1,069,080	293,327	105,174	99,052	10.00
11.00 01100	CAFETERIA	0	75,225	26,972	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,348,746	90,018	32,276	222,546	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	155,533	202,047	72,445	21,014	14.00
15.00 01500	PHARMACY	1,186,632	106,783	38,288	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	880,549	56,646	20,311	120,360	16.00
17.00 01700	SOCIAL SERVICE	718,144	51,478	18,458	110,678	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	11,363,615	1,954,278	700,718	1,478,342	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	995,462	324,293	116,277	67,435	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	776,987	126,309	45,289	31,707	54.00
60.00 06000	LABORATORY	1,102,463	19,447	6,973	28,033	60.00
65.00 06500	RESPIRATORY THERAPY	2,312,128	118,577	42,517	368,384	65.00
66.00 06600	PHYSICAL THERAPY	1,647,312	128,912	46,222	32	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	2,021,749	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,336,282	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	955,457	7,968	2,857	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)	53,697,391	5,167,581	1,852,867	3,131,946	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,680	2,037	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	3,015	0	0	465	194.00
194.01 07951	IDLE SPACE	0	485,039	0	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	0	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		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	53,700,406	5,658,300	1,854,904	3,132,411	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142009

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

Worksheet B
Part I
Date/Time Prepared:
1/24/2017 2:51 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	11,141,233				5.00	
7.00	00700	OPERATION OF PLANT	1,177,192	5,622,781			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	82,980	49,442	445,790		8.00	
9.00	00900	HOUSEKEEPING	279,675	189,360	0	1,525,208	9.00	
10.00	01000	DIETARY	414,844	443,491	0	125,635	2,550,603	10.00
11.00	01100	CAFETERIA	27,062	113,736	0	32,220	1,026,980	11.00
13.00	01300	NURSING ADMINISTRATION	448,462	136,101	0	38,556	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	119,435	305,482	0	86,539	0	14.00
15.00	01500	PHARMACY	352,635	161,448	0	45,736	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	285,419	85,645	0	24,262	0	16.00
17.00	01700	SOCIAL SERVICE	237,991	77,832	0	22,049	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,103,597	2,954,738	445,790	837,036	1,420,307	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	398,118	490,309	0	138,898	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	259,581	190,971	0	54,099	0	54.00
60.00	06000	LABORATORY	306,351	29,403	0	8,329	0	60.00
65.00	06500	RESPIRATORY THERAPY	752,457	179,281	0	50,788	0	65.00
66.00	06600	PHYSICAL THERAPY	482,592	194,907	0	55,215	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	535,359	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	618,647	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	255,871	12,047	0	3,413	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)	11,138,268	5,614,193	445,790	1,522,775	2,447,287	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,043	8,588	0	2,433	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	922	0	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	0	0	0	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	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	103,316	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)	11,141,233	5,622,781	445,790	1,525,208	2,550,603	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part I Date/Time Prepared: 1/24/2017 2:51 pm
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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	1,302,195					11.00
13.00	01300	82,071	2,398,776				13.00
14.00	01400	27,357	0	989,852			14.00
15.00	01500	0	0	4,055	1,895,577		15.00
16.00	01600	60,185	0	382	0	1,533,759	16.00
17.00	01700	38,300	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	831,655	2,322,382	11,950	26,139	717,114	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	27,357	76,394	2,237	0	12,707	50.00
54.00	05400	16,414	0	388	0	74,796	54.00
60.00	06000	32,828	0	1,378	0	131,527	60.00
65.00	06500	186,028	0	4,491	0	195,773	65.00
66.00	06600	0	0	235	6	51,803	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	964,735	0	52,362	71.00
73.00	07300	0	0	0	1,869,432	264,878	73.00
74.00	07400	0	0	1	0	32,799	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		1,302,195	2,398,776	989,852	1,895,577	1,533,759	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		1,302,195	2,398,776	989,852	1,895,577	1,533,759	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 142009

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

Worksheet B
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	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	1,274,930			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,274,930	30,442,591	0	30,442,591
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	0	2,649,487	0	2,649,487
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,576,541	0	1,576,541
60.00	06000	LABORATORY	0	1,666,732	0	1,666,732
65.00	06500	RESPIRATORY THERAPY	0	4,210,424	0	4,210,424
66.00	06600	PHYSICAL THERAPY	0	2,607,236	0	2,607,236
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	3,574,205	0	3,574,205
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,089,239	0	5,089,239
74.00	07400	RENAL DIALYSIS	0	1,270,413	0	1,270,413
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
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,274,930	53,086,868	0	53,086,868
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,781	0	20,781
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	4,402	0	4,402
194.01	07951	IDLE SPACE	0	485,039	0	485,039
194.02	07952	REGIONAL OFFICE	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	194.03
194.04	07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05	07955	REG NURSG OFFICE	0	0	0	194.05
194.06	07956	CONTACT CENTER	0	0	0	194.06
194.07	07957	CENTRALIZED ADMINISTRATION DEPT	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	103,316	0	103,316
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,274,930	53,700,406	0	53,700,406

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 142009

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	361,666	583,380	209,174	5.00
7.00 00700	OPERATION OF PLANT	0	870,948	312,284	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	32,701	11,725	8.00
9.00 00900	HOUSEKEEPING	0	125,244	44,907	9.00
10.00 01000	DIETARY	0	293,327	105,174	10.00
11.00 01100	CAFETERIA	0	75,225	26,972	11.00
13.00 01300	NURSING ADMINISTRATION	0	90,018	32,276	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	202,047	72,445	14.00
15.00 01500	PHARMACY	0	106,783	38,288	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	56,646	20,311	16.00
17.00 01700	SOCIAL SERVICE	0	51,478	18,458	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	1,954,278	700,718	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	0	324,293	116,277	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	126,309	45,289	54.00
60.00 06000	LABORATORY	0	19,447	6,973	60.00
65.00 06500	RESPIRATORY THERAPY	0	118,577	42,517	65.00
66.00 06600	PHYSICAL THERAPY	0	128,912	46,222	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	7,968	2,857	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
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	361,666	5,167,581	1,852,867	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,680	2,037	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	194.00
194.01 07951	IDLE SPACE	0	485,039	0	194.01
194.02 07952	REGIONAL OFFICE	0	0	0	194.02
194.03 07953	DISTRICT OFFICE	0	0	0	194.03
194.04 07954	NON MCR CERTIFIED UNIT	0	0	0	194.04
194.05 07955	REG NURSG OFFICE	0	0	0	194.05
194.06 07956	CONTACT CENTER	0	0	0	194.06
194.07 07957	CENTRALIZED ADMINISTRATIONS DEPT	0	0	0	194.07
194.08 07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	194.08
194.09 07958	VISITOR MEALS	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	194.11
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers			0	201.00
202.00	TOTAL (sum lines 118-201)	361,666	5,658,300	1,854,904	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet B Part II Date/Time Prepared: 1/24/2017 2:51 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	1,154,220				5.00
7.00	00700	OPERATION OF PLANT	121,956	1,305,188			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,597	11,477	64,500		8.00
9.00	00900	HOUSEKEEPING	28,974	43,955	0	243,080	9.00
10.00	01000	DIETARY	42,977	102,945	0	20,023	564,446
11.00	01100	CAFETERIA	2,804	26,401	0	5,135	227,270
13.00	01300	NURSING ADMINISTRATION	46,460	31,592	0	6,145	0
14.00	01400	CENTRAL SERVICES & SUPPLY	12,373	70,910	0	13,792	0
15.00	01500	PHARMACY	36,533	37,476	0	7,289	0
16.00	01600	MEDICAL RECORDS & LIBRARY	29,569	19,880	0	3,867	0
17.00	01700	SOCIAL SERVICE	24,656	18,067	0	3,514	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	425,127	685,868	64,500	133,402	314,312
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	41,245	113,813	0	22,137	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,892	44,329	0	8,622	0
60.00	06000	LABORATORY	31,738	6,825	0	1,328	0
65.00	06500	RESPIRATORY THERAPY	77,954	41,616	0	8,094	0
66.00	06600	PHYSICAL THERAPY	49,996	45,243	0	8,800	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	55,463	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	64,091	0	0	0	0
74.00	07400	RENAL DIALYSIS	26,508	2,797	0	544	0
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)	1,153,913	1,303,194	64,500	242,692	541,582
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212	1,994	0	388	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	NONALLOWABLE CLINICAL LIAISON	95	0	0	0	0
194.01	07951	IDLE SPACE	0	0	0	0	0
194.02	07952	REGIONAL OFFICE	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	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	0	22,864
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					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,154,220	1,305,188	64,500	243,080	564,446

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet B Part II Date/Time Prepared: 1/24/2017 2:51 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	363,807					11.00
13.00	01300	22,929	229,420				13.00
14.00	01400	7,643	0	379,210			14.00
15.00	01500	0	0	1,553	227,922		15.00
16.00	01600	16,815	0	146	0	147,234	16.00
17.00	01700	10,700	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	232,347	222,114	4,578	3,143	68,790	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	7,643	7,306	857	0	1,221	50.00
54.00	05400	4,586	0	149	0	7,185	54.00
60.00	06000	9,172	0	528	0	12,634	60.00
65.00	06500	51,972	0	1,721	0	18,805	65.00
66.00	06600	0	0	90	1	4,976	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	369,588	0	5,030	71.00
73.00	07300	0	0	0	224,778	25,443	73.00
74.00	07400	0	0	0	0	3,150	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		363,807	229,420	379,210	227,922	147,234	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		363,807	229,420	379,210	227,922	147,234	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part II Date/Time Prepared: 1/24/2017 2:51 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	126,873			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	126,873	4,936,050	0	4,936,050	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	634,792	0	634,792	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	263,361	0	263,361	54.00
60.00	06000	LABORATORY	0	88,645	0	88,645	60.00
65.00	06500	RESPIRATORY THERAPY	0	361,256	0	361,256	65.00
66.00	06600	PHYSICAL THERAPY	0	284,240	0	284,240	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	430,081	0	430,081	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	314,312	0	314,312	73.00
74.00	07400	RENAL DIALYSIS	0	43,824	0	43,824	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)	126,873	7,356,561	0	7,356,561	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,311	0	10,311	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	95	0	95	194.00
194.01	07951	IDLE SPACE	0	485,039	0	485,039	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	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	22,864	0	22,864	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)	126,873	7,874,870	0	7,874,870	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142009

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

Worksheet B-1
Date/Time Prepared:
1/24/2017 2:51 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	143,441				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		131,145			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	18,424,108		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,789	14,789	2,582,782	-11,141,233	5.00
7.00	00700	OPERATION OF PLANT	22,079	22,079	179,907	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	829	829	0	0	8.00
9.00	00900	HOUSEKEEPING	3,175	3,175	674,399	0	9.00
10.00	01000	DIETARY	7,436	7,436	582,602	0	10.00
11.00	01100	CAFETERIA	1,907	1,907	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,282	2,282	1,308,965	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,122	5,122	123,598	0	14.00
15.00	01500	PHARMACY	2,707	2,707	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,436	1,436	707,930	0	16.00
17.00	01700	SOCIAL SERVICE	1,305	1,305	650,981	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	49,542	49,542	8,695,263	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	8,221	8,221	396,637	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,202	3,202	186,491	0	54.00
60.00	06000	LABORATORY	493	493	164,884	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,006	3,006	2,166,750	0	65.00
66.00	06600	PHYSICAL THERAPY	3,268	3,268	186	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	202	202	0	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)	131,001	131,001	18,421,375	-11,141,233	42,062,937
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144	144	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	2,733	0	194.00
194.01	07951	IDLE SPACE	12,296	0	0	-485,039	194.01
194.02	07952	REGIONAL OFFICE	0	0	0	0	194.02
194.03	07953	DISTRICT OFFICE	0	0	0	0	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)	5,658,300	1,854,904	3,132,411		11,141,233
203.00		Unit cost multiplier (Wkst. B, Part I)	39.446881	14.143917	0.170017		0.264800
204.00		Cost to be allocated (per Wkst. B, Part II)			0		1,154,220
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.027433

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142009

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

Worksheet B-1

Date/Time Prepared:
1/24/2017 2:51 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	94,277				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	829	34,277			8.00
9.00	00900	HOUSEKEEPING	3,175	0	90,273		9.00
10.00	01000	DIETARY	7,436	0	7,436	152,617	10.00
11.00	01100	CAFETERIA	1,907	0	1,907	61,450	238
13.00	01300	NURSING ADMINISTRATION	2,282	0	2,282	0	15
14.00	01400	CENTRAL SERVICES & SUPPLY	5,122	0	5,122	0	5
15.00	01500	PHARMACY	2,707	0	2,707	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,436	0	1,436	0	11
17.00	01700	SOCIAL SERVICE	1,305	0	1,305	0	7
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	49,542	34,277	49,542	84,985	152
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	8,221	0	8,221	0	5
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,202	0	3,202	0	3
60.00	06000	LABORATORY	493	0	493	0	6
65.00	06500	RESPIRATORY THERAPY	3,006	0	3,006	0	34
66.00	06600	PHYSICAL THERAPY	3,268	0	3,268	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	202	0	202	0	0
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)	94,133	34,277	90,129	146,435	238
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144	0	144	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	0	0	0	0	0
194.03	07953	DISTRICT OFFICE	0	0	0	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	6,182	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)	5,622,781	445,790	1,525,208	2,550,603	1,302,195
203.00		Unit cost multiplier (Wkst. B, Part I)	59.641068	13.005514	16.895506	16.712444	5,471.407563
204.00		Cost to be allocated (per Wkst. B, Part II)	1,305,188	64,500	243,080	564,446	363,807
205.00		Unit cost multiplier (Wkst. B, Part II)	13.844183	1.881728	2.692721	3.698448	1,528.600840

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 142009

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

Worksheet B-1
Date/Time Prepared:
1/24/2017 2:51 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	157					13.00
14.00	01400	0	2,074,386				14.00
15.00	01500	0	8,497	2,368,956			15.00
16.00	01600	0	800	0	200,985,023		16.00
17.00	01700	0	0	0	0	34,277	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	152	25,043	32,667	93,968,334	34,277	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	5	4,688	0	1,665,131	0	50.00
54.00	05400	0	814	0	9,801,585	0	54.00
60.00	06000	0	2,888	0	17,235,855	0	60.00
65.00	06500	0	9,412	0	25,655,021	0	65.00
66.00	06600	0	493	7	6,788,524	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	2,021,749	0	6,861,689	0	71.00
73.00	07300	0	0	2,336,282	34,710,800	0	73.00
74.00	07400	0	2	0	4,298,084	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		157	2,074,386	2,368,956	200,985,023	34,277	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		2,398,776	989,852	1,895,577	1,533,759	1,274,930	202.00
203.00		15,278.828025	0.477178	0.800174	0.007631	37.194912	203.00
204.00		229,420	379,210	227,922	147,234	126,873	204.00
205.00		1,461.273885	0.182806	0.096212	0.000733	3.701403	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/24/2017 2:51 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		30,442,591	8,682	30,451,273	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		2,649,487	0	2,649,487	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,576,541	0	1,576,541	54.00
60.00	06000 LABORATORY		1,666,732	0	1,666,732	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,210,424	6,063	4,216,487	65.00
66.00	06600 PHYSICAL THERAPY	0	2,607,236	0	2,607,236	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		3,574,205	0	3,574,205	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		5,089,239	0	5,089,239	73.00
74.00	07400 RENAL DIALYSIS		1,270,413	0	1,270,413	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)		53,086,868	14,745	53,101,613	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		53,086,868	14,745	53,101,613	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142009

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

Worksheet C
Part I
Date/Time Prepared:
1/24/2017 2:51 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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,968,334		93,968,334			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	1,665,131	0	1,665,131	1.591158	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,801,585	0	9,801,585	0.160846	0.000000	54.00
60.00	06000	LABORATORY	17,235,855	0	17,235,855	0.096701	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	25,655,021	0	25,655,021	0.164117	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,788,524	0	6,788,524	0.384065	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	6,861,689	0	6,861,689	0.520893	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,710,800	0	34,710,800	0.146618	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,298,084	0	4,298,084	0.295577	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)	200,985,023	0	200,985,023			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	200,985,023	0	200,985,023			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/24/2017 2:51 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	1.591158		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.160846		54.00
60.00	06000 LABORATORY	0.096701		60.00
65.00	06500 RESPIRATORY THERAPY	0.164353		65.00
66.00	06600 PHYSICAL THERAPY	0.384065		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	0.520893		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.146618		73.00
74.00	07400 RENAL DIALYSIS	0.295577		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: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/24/2017 2:51 pm
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE		
				Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		30,442,591	8,682	30,451,273	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		2,649,487	0	2,649,487	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,576,541	0	1,576,541	54.00
60.00	06000 LABORATORY		1,666,732	0	1,666,732	60.00
65.00	06500 RESPIRATORY THERAPY	0	4,210,424	6,063	4,216,487	65.00
66.00	06600 PHYSICAL THERAPY	0	2,607,236	0	2,607,236	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		3,574,205	0	3,574,205	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		5,089,239	0	5,089,239	73.00
74.00	07400 RENAL DIALYSIS		1,270,413	0	1,270,413	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)		53,086,868	14,745	53,101,613	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		53,086,868	14,745	53,101,613	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 142009

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

Worksheet C
Part I
Date/Time Prepared:
1/24/2017 2:51 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	93,968,334		93,968,334		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	1,665,131	0	1,665,131	1.591158	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,801,585	0	9,801,585	0.160846	54.00
60.00	06000	LABORATORY	17,235,855	0	17,235,855	0.096701	60.00
65.00	06500	RESPIRATORY THERAPY	25,655,021	0	25,655,021	0.164117	65.00
66.00	06600	PHYSICAL THERAPY	6,788,524	0	6,788,524	0.384065	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	6,861,689	0	6,861,689	0.520893	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,710,800	0	34,710,800	0.146618	73.00
74.00	07400	RENAL DIALYSIS	4,298,084	0	4,298,084	0.295577	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)	200,985,023	0	200,985,023		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	200,985,023	0	200,985,023		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/24/2017 2:51 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: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet D Part I Date/Time Prepared: 1/24/2017 2:51 pm		
		Title XVIII		Hospital		PPS		
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		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	4,936,050	0	4,936,050	34,277	144.00	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)	4,936,050		4,936,050	34,277		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	13,409	1,930,896					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (Lines 30-199)	13,409	1,930,896					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part II Date/Time Prepared: 1/24/2017 2:51 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	634,792	1,665,131	0.381226	687,743	262,186	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	263,361	9,801,585	0.026869	4,024,096	108,123	54.00
60.00	06000 LABORATORY	88,645	17,235,855	0.005143	7,480,980	38,475	60.00
65.00	06500 RESPIRATORY THERAPY	361,256	25,655,021	0.014081	9,782,450	137,747	65.00
66.00	06600 PHYSICAL THERAPY	284,240	6,788,524	0.041871	2,622,294	109,798	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	430,081	6,861,689	0.062679	2,652,790	166,274	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	314,312	34,710,800	0.009055	12,869,063	116,529	73.00
74.00	07400 RENAL DIALYSIS	43,824	4,298,084	0.010196	1,906,587	19,440	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)	2,420,511	107,016,689		42,026,003	958,572	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet D Part III Date/Time Prepared: 1/24/2017 2:51 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	34,277	0.00	13,409	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)	34,277		13,409	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/24/2017 2:51 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00 09000 CLINIC	0	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	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	0	0	98.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/24/2017 2:51 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,665,131	0.000000	0.000000	687,743	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	9,801,585	0.000000	0.000000	4,024,096	54.00
60.00	06000 LABORATORY	0	17,235,855	0.000000	0.000000	7,480,980	60.00
65.00	06500 RESPIRATORY THERAPY	0	25,655,021	0.000000	0.000000	9,782,450	65.00
66.00	06600 PHYSICAL THERAPY	0	6,788,524	0.000000	0.000000	2,622,294	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	6,861,689	0.000000	0.000000	2,652,790	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	34,710,800	0.000000	0.000000	12,869,063	73.00
74.00	07400 RENAL DIALYSIS	0	4,298,084	0.000000	0.000000	1,906,587	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	107,016,689			42,026,003	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/24/2017 2:51 pm
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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: 142009

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

Worksheet D
Part V
Date/Time Prepared:
1/24/2017 2:51 pm

		Title XVIII			Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1.591158	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.160846	0	582,792	0	0	54.00
60.00	06000	LABORATORY	0.096701	0	6,838	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.164117	0	148,616	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.384065	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520893	0	20,696	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146618	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.295577	0	501,816	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	1,260,758	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	1,260,758	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part V Date/Time Prepared: 1/24/2017 2:51 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	93,740	0	54.00
60.00	06000 LABORATORY	661	0	60.00
65.00	06500 RESPIRATORY THERAPY	24,390	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	10,780	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	148,325	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)	277,896	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	277,896	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/24/2017 2:51 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)		34,277	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		34,277	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)		34,277	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)		13,409	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)		30,451,273	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)		30,451,273	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)		30,451,273	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)		888.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,912,422	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		11,912,422	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/24/2017 2:51 pm
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	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)					8,912,091 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					20,824,513 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,930,896 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					958,572 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,889,468 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,935,045 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: 142009		Period: From 09/01/2015 To 08/31/2016		Worksheet D-1 Date/Time Prepared: 1/24/2017 2:51 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	4,936,050	30,451,273	0.162097	0	0	90.00
91.00	Nursing School cost	0	30,451,273	0.000000	0	0	91.00
92.00	Allied health cost	0	30,451,273	0.000000	0	0	92.00
93.00	All other Medical Education	0	30,451,273	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/24/2017 2:51 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		34,277	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		34,277	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)		34,277	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)		6,622	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)		30,442,591	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)		30,442,591	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)		30,442,591	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)		888.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,881,197	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)		5,881,197	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/24/2017 2:51 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)
Title XIX		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
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)					3,814,658
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,695,855
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 142009

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

Worksheet D-1
Date/Time Prepared:
1/24/2017 2:51 pm

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Hospital Cost		
				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	4,936,050	30,442,591	0.162143	0	0	90.00
91.00 Nursing School cost	0	30,442,591	0.000000	0	0	91.00
92.00 Allied health cost	0	30,442,591	0.000000	0	0	92.00
93.00 All other Medical Education	0	30,442,591	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 142009

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

Worksheet D-2

Date/Time Prepared:
1/24/2017 2:51 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	34,277	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	34,277	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: 142009

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

Worksheet D-2

Date/Time Prepared:
1/24/2017 2:51 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: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D-2 Date/Time Prepared: 1/24/2017 2:51 pm
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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	13,409	6,622	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	0	0	0	0	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	0	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	0	0	0	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)						20.00
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						21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER						22.00
23.00	CLINIC	0	0	0	0	0	23.00
24.00	EMERGENCY	0	0	0	0	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	0	0	27.00
28.00	Total (sum of lines 20 and 27)						28.00
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: 142009

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

Worksheet D-2

Date/Time Prepared:
1/24/2017 2:51 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: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D-3 Date/Time Prepared: 1/24/2017 2:51 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		36,608,362		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.591158	687,743	1,094,308	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.160846	4,024,096	647,260	54.00
60.00	06000 LABORATORY	0.096701	7,480,980	723,418	60.00
65.00	06500 RESPIRATORY THERAPY	0.164353	9,782,450	1,607,775	65.00
66.00	06600 PHYSICAL THERAPY	0.384065	2,622,294	1,007,131	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	0.520893	2,652,790	1,381,820	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.146618	12,869,063	1,886,836	73.00
74.00	07400 RENAL DIALYSIS	0.295577	1,906,587	563,543	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)		42,026,003	8,912,091	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)		42,026,003		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet D-3 Date/Time Prepared: 1/24/2017 2:51 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		18,025,611		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.591158	365,530	581,616	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.160846	1,058,666	170,282	54.00
60.00	06000 LABORATORY	0.096701	1,864,072	180,258	60.00
65.00	06500 RESPIRATORY THERAPY	0.164117	3,857,193	633,031	65.00
66.00	06600 PHYSICAL THERAPY	0.384065	961,510	369,282	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	0.520893	1,271,040	662,076	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.146618	7,611,621	1,116,001	73.00
74.00	07400 RENAL DIALYSIS	0.295577	345,468	102,112	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)		17,335,100	3,814,658	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)		17,335,100		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part B Date/Time Prepared: 1/24/2017 2:51 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		277,896	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)		277,896	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,260,758	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)		1,260,758	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)		1,260,758	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		982,862	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)		277,896	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)		252,152	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)		25,744	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)		25,744	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		25,744	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)		25,744	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)		25,744	40.00
40.01	Sequestration adjustment (see instructions)		515	40.01
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		25,229	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: 142009

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

Worksheet E-1
Part I
Date/Time Prepared:
1/24/2017 2:51 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		21,804,499		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	11/25/2015	87,600		0	3.01
3.02		05/19/2016	77,700		0	3.02
3.03		11/23/2016	974,100		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	04/12/2016	1,700,000		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)		-560,600		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)		21,243,899		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		25,229	6.01
6.02	SETTLEMENT TO PROGRAM		53,533		0	6.02
7.00	Total Medicare program liability (see instructions)		21,190,366		25,229	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		Provider CCN: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part IV Date/Time Prepared: 1/24/2017 2:51 pm
		Title XVII I	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		21,088,008	1.00
2.00	Outlier Payments		1,367,542	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		22,455,550	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 hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		22,455,550	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		22,455,550	9.00
10.00	Deductibles		42,056	10.00
11.00	Subtotal (line 9 minus line 10)		22,413,494	11.00
12.00	Coinsurance		1,650,712	12.00
13.00	Subtotal (line 11 minus line 12)		20,762,782	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		1,323,139	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		860,040	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,088,468	16.00
17.00	Subtotal (sum of lines 13 and 15)		21,622,822	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)		21,622,822	22.00
22.01	Sequestration adjustment (see instructions)		432,456	22.01
23.00	Interim payments		21,243,899	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)		-53,533	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: 142009	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 1/24/2017 2:51 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		9,695,855		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)		9,695,855	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)		9,695,855	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		18,025,611		8.00
9.00	Ancillary service charges		17,335,100	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)		35,360,711	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)		35,360,711	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		25,664,856	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)		9,695,855	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)		9,695,855	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)		9,695,855	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)		9,695,855	0	36.00
37.00	OTHER ADJUSTMENTS		0	0	37.00
37.01	OTHER ADJUSTMENTS		0	0	37.01
38.00	Subtotal (line 36 ± line 37)		9,695,855	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)		9,695,855	0	40.00
41.00	Interim payments		7,668,925		41.00
42.00	Balance due provider/program (line 40 minus line 41)		2,026,930		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: 142009

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

Worksheet G

Date/Time Prepared:
1/24/2017 2:51 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	115,860	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	15,934,132	0	0	0	4.00
5.00	Other receivable	91,875	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,529,141	0	0	0	6.00
7.00	Inventory	429,271	0	0	0	7.00
8.00	Prepaid expenses	122,810	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)	13,164,807	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	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	231,365	0	0	0	15.00
16.00	Accumulated depreciation	-226,266	0	0	0	16.00
17.00	Leasehold improvements	11,061,395	0	0	0	17.00
18.00	Accumulated depreciation	-9,923,550	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	10,621,258	0	0	0	23.00
24.00	Accumulated depreciation	-8,988,238	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)	2,775,964	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	38,884	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	38,884	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,979,655	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,357,917	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,221,189	0	0	0	38.00
39.00	Payroll taxes payable	3,477	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	1,611,325	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,193,908	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	-16,627,421	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-16,627,421	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-12,433,513	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	28,413,168				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)	28,413,168	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,979,655	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 142009

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

Worksheet G-1

Date/Time Prepared:
1/24/2017 2:51 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		27,993,534		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		419,633			2.00
3.00	Total (sum of line 1 and line 2)		28,413,167		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	1		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)		1		0	10.00
11.00	Subtotal (line 3 plus line 10)		28,413,168		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)		28,413,168		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: 142009

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/24/2017 2:51 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	93,968,334		93,968,334	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)	93,968,334		93,968,334	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)	93,968,334		93,968,334	17.00
18.00	Ancillary services	107,016,689	0	107,016,689	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)	200,985,023	0	200,985,023	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		54,449,686		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)		54,449,686		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 142009

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

Worksheet G-3

Date/Time Prepared:
1/24/2017 2:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	200,985,023	1.00
2.00	Less contractual allowances and discounts on patients' accounts	146,298,874	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,686,149	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	54,449,686	4.00
5.00	Net income from service to patients (line 3 minus line 4)	236,463	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	9,222	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	61,038	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	2,116	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	110,794	24.00
25.00	Total other income (sum of lines 6-24)	183,170	25.00
26.00	Total (line 5 plus line 25)	419,633	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)	419,633	29.00