

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: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S Parts I-III Date/Time Prepared: 1/12/2017 11:55 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/12/2017 Time: 11:55 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by Kindred Hospital St. Louis (262010) 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	-31,160	-4,957	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00 Total	0	-31,160	-4,957	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 262010		Period: From 09/01/2015 To 08/31/2016		Worksheet S-2 Part I Date/Time Prepared: 1/12/2017 11:54 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4930 Lindell Boulevard			PO Box:						1.00		
2.00	City: St. Louis			State: MO		Zip Code: 63108		County: St. Louis City		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		Kindred Hospital St. Louis		262010	41180	2	08/30/1991	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2015		08/31/2016		20.00	
21.00	Type of Control (see instructions)						4				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/12/2017 11:54 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00	2.00	3.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				Y	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				Y	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V 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:	13,031	0	107,887		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: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/12/2017 11:54 am
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		1.00	2.00					
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		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	166.00
166.01							0.00	166.01
166.02							0.00	166.02
166.03							0.00	166.03
							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)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part I Date/Time Prepared: 1/12/2017 11:54 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00
				1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part II Date/Time Prepared: 1/12/2017 11:54 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/31/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/31/2016	Y	10/31/2016
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: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part II Date/Time Prepared: 1/12/2017 11:54 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S-2 Part II Date/Time Prepared: 1/12/2017 11:54 am
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		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: 262010

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

Worksheet S-3
Part I
Date/Time Prepared:
1/12/2017 11:54 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	60	24,872	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)		60	24,872	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)		60	24,872	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)		60				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: 262010

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

Worksheet S-3
Part I
Date/Time Prepared:
1/12/2017 11:54 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10,093	2,962	17,995			1.00
2.00 HMO and other (see instructions)	1,626	5				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)	10,093	2,962	17,995			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)	10,093	2,962	17,995	0.00	169.10	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	169.10	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	140					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 262010

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

Worksheet S-3
Part I
Date/Time Prepared:
1/12/2017 11:54 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	398	117	706	1.00
2.00 HMO and other (see instructions)			61	1		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	398	117	706	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: 262010

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

Worksheet S-3
Part II
Date/Time Prepared:
1/12/2017 11:54 am

	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 II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	9,881,969	0	9,881,969	351,668.03	28.10
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	5,337	5,337	146.00	36.55
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,225,660	0	4,225,660	73,123.00	57.79
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		900,943	0	900,943	8,916.00	101.05
14.00	Home office salaries & wage-related costs		1,462,527	0	1,462,527	23,975.85	61.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,546,838	0	1,546,838		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		836	0	836		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	88,808	0	88,808	1,772.50	50.10
27.00	Administrative & General	5.00	1,624,480	0	1,624,480	40,902.55	39.72
28.00	Administrative & General under contract (see inst.)		2,089	0	2,089	63.00	33.16
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	251,522	0	251,522	17,098.00	14.71
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	59,984	0	59,984	2,220.00	27.02
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,197,501	0	1,197,501	29,070.00	41.19
39.00	Central Services and Supply	14.00	97,129	0	97,129	5,845.00	16.62
40.00	Pharmacy	15.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 262010

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

Worksheet S-3
Part II
Date/Time Prepared:
1/12/2017 11:54 am

	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	16.00 402,808	0	402,808	14,978.00	26.89	41.00
42.00	Social Service	17.00 645,545	-5,337	640,208	16,980.00	37.70	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 262010

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

Worksheet S-3
Part III
Date/Time Prepared:
1/12/2017 11:54 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	9,884,058	0	9,884,058	351,731.03	28.10	1.00
2.00	Excluded area salaries (see instructions)	0	5,337	5,337	146.00	36.55	2.00
3.00	Subtotal salaries (line 1 minus line 2)	9,884,058	-5,337	9,878,721	351,585.03	28.10	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,589,130	0	6,589,130	106,014.85	62.15	4.00
5.00	Subtotal wage-related costs (see inst.)	1,546,838	0	1,546,838	0.00	15.66	5.00
6.00	Total (sum of lines 3 thru 5)	18,020,026	-5,337	18,014,689	457,599.88	39.37	6.00
7.00	Total overhead cost (see instructions)	4,369,866	-5,337	4,364,529	128,929.05	33.85	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 1/12/2017 11:54 am
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		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)	483,362	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-6,372	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,662	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)	39,606	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	211,464	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	700,834	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	86,450	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	25,832	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,546,838	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet S-10 Date/Time Prepared: 1/12/2017 11:54 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.263087	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		403,647	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		-403,647	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		-106,194	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		-106,194	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		-106,194	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 262010

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

Worksheet A
Date/Time Prepared:
1/12/2017 11:54 am

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		1,965,704	1,965,704	78,374	2,044,078	1.00
2.00	00200		572,303	572,303	149,093	721,396	2.00
3.00	00300		227,467	227,467	-227,467	0	3.00
4.00	00400	88,808	1,655,408	1,744,216	0	1,744,216	4.00
5.00	00500	1,624,480	4,811,164	6,435,644	0	6,435,644	5.00
7.00	00700	0	1,215,766	1,215,766	0	1,215,766	7.00
8.00	00800	0	97,062	97,062	0	97,062	8.00
9.00	00900	251,522	103,251	354,773	0	354,773	9.00
10.00	01000	59,984	482,476	542,460	0	542,460	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,197,501	24,259	1,221,760	0	1,221,760	13.00
14.00	01400	97,129	15,706	112,835	0	112,835	14.00
15.00	01500	0	1,112,282	1,112,282	0	1,112,282	15.00
16.00	01600	402,808	97,770	500,578	0	500,578	16.00
17.00	01700	645,545	48,460	694,005	-5,663	688,342	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,961,639	3,024,903	6,986,542	0	6,986,542	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	169,065	129,314	298,379	0	298,379	50.00
54.00	05400	70,616	268,457	339,073	0	339,073	54.00
60.00	06000	81,170	350,740	431,910	0	431,910	60.00
65.00	06500	1,231,702	158,613	1,390,315	0	1,390,315	65.00
66.00	06600	0	1,144,491	1,144,491	0	1,144,491	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	1,098,583	1,098,583	0	1,098,583	71.00
73.00	07300	0	1,470,045	1,470,045	0	1,470,045	73.00
74.00	07400	0	399,228	399,228	0	399,228	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		9,881,969	20,473,452	30,355,421	-5,663	30,349,758	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	5,663	5,663	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		9,881,969	20,473,452	30,355,421	0	30,355,421	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 262010

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

Worksheet A
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	114,801	2,158,879	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	199,906	921,302	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,439	1,741,777	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	60,111	6,495,755	5.00
7.00	00700	OPERATION OF PLANT	-2,606	1,213,160	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,062	8.00
9.00	00900	HOUSEKEEPING	0	354,773	9.00
10.00	01000	DIETARY	-1,465	540,995	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,221,760	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	112,835	14.00
15.00	01500	PHARMACY	0	1,112,282	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,411	499,167	16.00
17.00	01700	SOCIAL SERVICE	0	688,342	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-140,152	6,846,390	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	298,379	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-43,694	295,379	54.00
60.00	06000	LABORATORY	0	431,910	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,390,315	65.00
66.00	06600	PHYSICAL THERAPY	-87,377	1,057,114	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	1,098,583	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,470,045	73.00
74.00	07400	RENAL DIALYSIS	-1,054	398,174	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)	94,620	30,444,378	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	5,663	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)	94,620	30,450,041	200.00

RECLASSIFICATIONS

Provider CCN: 262010

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

Worksheet A-6

Date/Time Prepared:
1/12/2017 11:54 am

		Increases			
		Cost Center	Line #	Salary	Other
		2.00	3.00	4.00	5.00
A - RECLASS NON ALLOWABLE CASE MANAGER					
1.00	NONALLOWABLE CLINICAL LIAISON		194.00	5,337	326
	TOTALS			5,337	326
500.00	Grand Total: Increases			5,337	326

1.00
500.00

Provider CCN: 262010

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

Worksheet A-6
Date/Time Prepared:
1/12/2017 11:54 am

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - RECLASS NON ALLOWABLE CASE MANAGER							
1.00	SOCIAL SERVICE	17.00	5,337	326	0		1.00
TOTALS			5,337	326			
500.00	Grand Total: Decreases		5,337	326			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

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

Worksheet A-7
Part I
Date/Time Prepared:
1/12/2017 11:54 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	1,916,121	1,090,510	0	1,090,510	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	5,234,602	519,139	0	519,139	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	7,150,723	1,609,649	0	1,609,649	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	7,150,723	1,609,649	0	1,609,649	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	0	0			3.00
4.00	Building Improvements	3,006,631	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	5,719,579	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	8,726,210	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	8,726,210	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

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

Worksheet A-7
Part II
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	105,414	1,860,290	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	220,926	351,377	0	0	0	2.00
3.00	Total (sum of lines 1-2)	326,340	2,211,667	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,965,704				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	572,303				2.00
3.00	Total (sum of lines 1-2)	0	2,538,007				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 262010

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

Worksheet A-7
Part III
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,006,631	0	3,006,631	0.344552	9,867	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,719,579	0	5,719,579	0.655448	18,771	2.00
3.00	Total (sum of lines 1-2)	8,726,210	0	8,726,210	1.000000	28,638	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	68,507	0	78,374	230,238	1,860,290	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	130,322	0	149,093	420,832	351,377	2.00
3.00	Total (sum of lines 1-2)	198,829	0	227,467	651,070	2,211,667	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	-156	68,507	0	2,158,879	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	18,771	130,322	0	921,302	2.00
3.00	Total (sum of lines 1-2)	0	18,615	198,829	0	3,080,181	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 262010

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

Worksheet A-8

Date/Time Prepared:
1/12/2017 11:54 am

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	-4,090		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)	B	-2,539		CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-21,354		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-2,606		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	-188,206				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,102,329				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	50		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	-3,285		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	B	-1,515		DIETARY	10.00	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	-16,679		ADMINISTRATIVE & GENERAL	5.00	0	33.01

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	
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	-20,247	ADMINISTRATIVE & GENERAL		5.00	0 33.05
33.06	PATIENT PERSONAL SERVICES EXPENSE	-369	ADMINISTRATIVE & GENERAL		5.00	0 33.06
33.07	PROFESSIONAL FEES - CAPITAL PROJECT	-5,674	ADMINISTRATIVE & GENERAL		5.00	0 33.07
33.08	MEDICARE BAD DEBT - PART A	-651,804	ADMINISTRATIVE & GENERAL		5.00	0 33.08
33.09		0			0.00	0 33.09
33.10	OTHER MEDICARE NON ALLOWABLE	-83,457	ADMINISTRATIVE & GENERAL		5.00	0 33.10
33.11	OTHER OPERATING - PATIENT RELATIONS	-1,032	ADMINISTRATIVE & GENERAL		5.00	0 33.11
33.12	OTHER OPERATING - PUBLIC RELATIONS	-528	ADMINISTRATIVE & GENERAL		5.00	0 33.12
33.13	OTHER OPERATING - MARKETING	-132,285	ADMINISTRATIVE & GENERAL		5.00	0 33.13
33.14	OTHER OPERATING - INTEREST	-956	ADMINISTRATIVE & GENERAL		5.00	0 33.14
33.15		0			0.00	0 33.15
33.16		0			0.00	0 33.16
33.17	OTHER OPER - LITIGATION SETTLEMENT	-25,000	ADMINISTRATIVE & GENERAL		5.00	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	-3,372	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	-834	ADMINISTRATIVE & GENERAL		5.00	0 33.23
33.24		0			0.00	0 33.24
33.25	OTHER OPERATING - PENALTIES OTHER	12	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	-12,265	ADMINISTRATIVE & GENERAL		5.00	0 33.28
33.29	CABLE TV AND SATELLITE	-6,633	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	-63,866	ADMINISTRATIVE & GENERAL		5.00	0 33.32
33.33		0			0.00	0 33.33
33.34	MALPRACTICE TAIL LIABILITY	-10,485	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	-334	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	-30,335	ADMINISTRATIVE & GENERAL		5.00	0 33.43
33.44	DISTRICT OFC SALES AND MKT BENEFITS	-2,439	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.44
33.45	BUSINESS INTERRUPTIONS INS PREMIUM	-10,023	CAP REL COSTS-BLDG & FIXT		1.00	12 33.45
34.00	MEDICARE VS BOOK BLDG	117,596	CAP REL COSTS-BLDG & FIXT		1.00	9 34.00
34.01	MEDICARE VS BOOK MOV EQUIP	-56,318	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.01
34.02		0			0.00	0 34.02
34.03	ASSET ADD-ON BLDG	9,767	CAP REL COSTS-BLDG & FIXT		1.00	9 34.03
34.04	ASSET ADD-ON MOV EQUIP	258,185	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	-15,256	ADMINISTRATIVE & GENERAL		5.00	0 34.08
34.09		0			0.00	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	-1,961	CAP REL COSTS-MVBLE EQUIP		2.00	9 34.13
34.14		0			0.00	0 34.14

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
34.15		0			0	34.15
34.16		0			0	34.16
34.17		0			0	34.17
34.18		0			0	34.18
34.19		0			0	34.19
34.20		0			0	34.20
34.21		0			0	34.21
34.22		0			0	34.22
34.23		0			0	34.23
34.24		0			0	34.24
34.25		0			0	34.25
34.26	FRA TAX-ADJUST TO ACTUAL	A	-17,573	ADMINISTRATIVE & GENERAL	5.00	0 34.26
34.27			0		0.00	0 34.27
34.28			0		0.00	0 34.28
35.00			0		0.00	0 35.00
35.01	PHYSICIAN FEE ADJUSTMENT	A	-5,179	ADMINISTRATIVE & GENERAL	5.00	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	PHYSICIAN FEE ADJUSTMENT	A	4,193	MEDICAL RECORDS & LIBRARY	16.00	0 35.09
35.10			0		0.00	0 35.10
35.11	PHYSICIAN FEE ADJUSTMENT	A	-4,192	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	PHYSICIAN FEE ADJUSTMENT	A	2,791	RADIOLOGY-DIAGNOSTIC	54.00	0 35.15
35.16			0		0.00	0 35.16
35.17	PHYSICIAN FEE ADJUSTMENT	A	2,388	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.)		94,620			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: 262010
 Period: From 09/01/2015 To 08/31/2016
 Worksheet A-8-1
 Date/Time Prepared: 1/12/2017 11:54 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Home Office Costs	2,285,198	1,095,492 1.00
2.00	0.00			0	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Workers Comp Premium	200,646	200,646 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	Liability Insurance	120,643	120,643 4.00
4.01	66.00	PHYSICAL THERAPY	Therapy Services	1,048,948	1,136,325 4.01
5.00	0			3,655,435	2,553,106 5.00

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

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

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

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

6.00	B	KH01	100.00	Admin & Gen	100.00	6.00
7.00	B	KH01	100.00	Cornerstone	100.00	7.00
8.00	B	KH01	100.00	Cornerstone	100.00	8.00
9.00	B	KH01	100.00	RehabCare	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet A-8-1 Date/Time Prepared: 1/12/2017 11:54 am
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,189,706	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-87,377	0		4.01
5.00	1,102,329			5.00

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

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

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

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

6.00	HomeOffice Cost		6.00
7.00	Worker Comp Ins		7.00
8.00	Liability Insur		8.00
9.00	Therapy Svcs		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 262010

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

Worksheet A-8-2

Date/Time Prepared:
1/12/2017 11:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	436,401	0	436,401	177,200	4,364	1.00
2.00	74.00	DR. B	1,881	0	1,881	177,200	11	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	54.00	DR. D	43,566	43,566	0	225,300	0	4.00
5.00	30.00	DR. E	4,735	0	4,735	177,200	24	5.00
6.00	30.00	DR. F	4,640	0	4,640	177,200	32	6.00
7.00	30.00	DR. G	3,553	0	3,553	177,200	25	7.00
8.00	65.00	DR. H	1,663	1,663	0	177,200	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	30.00	DR. K	441,350	0	441,350	177,200	4,414	11.00
12.00	54.00	DR. L	2,791	2,791	0	225,300	0	12.00
13.00	16.00	DR. M	4,193	0	4,193	177,200	22	13.00
14.00	74.00	DR. N	195	0	195	177,200	1	14.00
15.00	65.00	DR. O	725	725	0	177,200	0	15.00
16.00	54.00	DR. P	128	128	0	225,300	0	16.00
200.00			945,821	48,873	896,948		8,893	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	371,779	18,589	0	0	0	1.00
2.00	74.00	DR. B	937	47	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	54.00	DR. D	0	0	0	0	0	4.00
5.00	30.00	DR. E	2,045	102	0	0	0	5.00
6.00	30.00	DR. F	2,726	136	0	0	0	6.00
7.00	30.00	DR. G	2,130	107	0	0	0	7.00
8.00	65.00	DR. H	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	30.00	DR. K	376,039	18,802	0	0	0	11.00
12.00	54.00	DR. L	0	0	0	0	0	12.00
13.00	16.00	DR. M	1,874	94	0	0	0	13.00
14.00	74.00	DR. N	85	4	0	0	0	14.00
15.00	65.00	DR. O	0	0	0	0	0	15.00
16.00	54.00	DR. P	0	0	0	0	0	16.00
200.00			757,615	37,881	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	371,779	64,622	64,622	1.00
2.00	74.00	DR. B	0	937	944	944	2.00
3.00	0.00		0	0	0	0	3.00
4.00	54.00	DR. D	0	0	0	43,566	4.00
5.00	30.00	DR. E	0	2,045	2,690	2,690	5.00
6.00	30.00	DR. F	0	2,726	1,914	1,914	6.00
7.00	30.00	DR. G	0	2,130	1,423	1,423	7.00
8.00	65.00	DR. H	0	0	0	1,663	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
11.00	30.00	DR. K	0	376,039	65,311	65,311	11.00
12.00	54.00	DR. L	0	0	0	2,791	12.00
13.00	16.00	DR. M	0	1,874	2,319	2,319	13.00
14.00	74.00	DR. N	0	85	110	110	14.00
15.00	65.00	DR. O	0	0	0	725	15.00
16.00	54.00	DR. P	0	0	0	128	16.00
200.00			0	757,615	139,333	188,206	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

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

Worksheet B
Part I
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,158,879	2,158,879			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	921,302		921,302		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,741,777	6,138	2,620	1,750,535	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,495,755	349,340	149,081	290,377	5.00
7.00 00700	OPERATION OF PLANT	1,213,160	112,617	48,059	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	97,062	46,628	19,899	0	8.00
9.00 00900	HOUSEKEEPING	354,773	32,699	13,954	44,960	9.00
10.00 01000	DIETARY	540,995	73,386	31,317	10,722	10.00
11.00 01100	CAFETERIA	0	27,702	11,822	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,221,760	69,884	29,823	214,055	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	112,835	131,347	56,052	17,362	14.00
15.00 01500	PHARMACY	1,112,282	131,740	56,220	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	499,167	49,068	20,940	72,002	16.00
17.00 01700	SOCIAL SERVICE	688,342	31,046	13,249	114,438	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,846,390	891,685	380,527	708,144	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	298,379	16,448	7,019	30,221	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	295,379	31,991	13,652	12,623	54.00
60.00 06000	LABORATORY	431,910	39,113	16,691	14,509	60.00
65.00 06500	RESPIRATORY THERAPY	1,390,315	50,367	21,494	220,168	65.00
66.00 06600	PHYSICAL THERAPY	1,057,114	37,381	15,953	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	1,098,583	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,470,045	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	398,174	30,299	12,930	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)	30,444,378	2,158,879	921,302	1,749,581	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	5,663	0	0	954	194.00
194.01 07951	IDLE SPACE	0	0	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)	30,450,041	2,158,879	921,302	1,750,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

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

Worksheet B
Part I
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	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	7,284,553				5.00
7.00	00700	OPERATION OF PLANT	432,012	1,805,848			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,442	49,802	264,833		8.00
9.00	00900	HOUSEKEEPING	140,369	34,924	0	621,679	9.00
10.00	01000	DIETARY	206,416	78,380	0	28,311	10.00
11.00	01100	CAFETERIA	12,429	29,587	0	10,687	11.00
13.00	01300	NURSING ADMINISTRATION	482,856	74,640	0	26,960	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	99,870	140,285	0	50,672	14.00
15.00	01500	PHARMACY	408,870	140,706	0	50,824	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	201,623	52,407	0	18,930	16.00
17.00	01700	SOCIAL SERVICE	266,369	33,159	0	11,977	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,775,634	952,368	264,833	344,001	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	110,710	17,567	0	6,345	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,206	34,168	0	12,342	54.00
60.00	06000	LABORATORY	157,928	41,775	0	15,089	60.00
65.00	06500	RESPIRATORY THERAPY	529,025	53,794	0	19,431	65.00
66.00	06600	PHYSICAL THERAPY	349,188	39,925	0	14,421	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	345,457	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	462,266	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	138,802	32,361	0	11,689	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)	7,282,472	1,805,848	264,833	621,679	969,527
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	2,081	0	0	0	194.00
194.01	07951	IDLE SPACE	0	0	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 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	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	0	201.00
202.00		TOTAL (sum lines 118-201)	7,284,553	1,805,848	264,833	621,679	969,527

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

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

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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	362,771					11.00
13.00	01300	36,277	2,156,255				13.00
14.00	01400	7,774	0	616,197			14.00
15.00	01500	0	0	7,500	1,908,142		15.00
16.00	01600	18,139	0	247	0	932,523	16.00
17.00	01700	20,730	0	237	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	209,889	2,104,297	15,972	1,190	356,848	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	5,182	51,958	0	0	3,764	50.00
54.00	05400	2,591	0	665	0	17,789	54.00
60.00	06000	5,182	0	0	0	82,693	60.00
65.00	06500	57,007	0	3,984	0	215,440	65.00
66.00	06600	0	0	2,267	0	43,800	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	585,325	0	31,541	71.00
73.00	07300	0	0	0	1,906,952	167,392	73.00
74.00	07400	0	0	0	0	13,256	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		362,771	2,156,255	616,197	1,908,142	932,523	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		362,771	2,156,255	616,197	1,908,142	932,523	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 262010

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

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Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	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	1,179,547			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,179,547	17,730,308	0	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	547,593	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	532,406	0	54.00
60.00	06000	LABORATORY	0	804,890	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,561,025	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,560,049	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	2,060,906	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,006,655	0	73.00
74.00	07400	RENAL DIALYSIS	0	637,511	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
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,179,547	30,441,343	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	8,698	0	194.00
194.01	07951	IDLE SPACE	0	0	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 ADMISSIONS 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	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,179,547	30,450,041	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 262010

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	6,138	2,620	8,758	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	207,045	349,340	149,081	705,466	5.00
7.00 00700	OPERATION OF PLANT	0	112,617	48,059	160,676	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	46,628	19,899	66,527	8.00
9.00 00900	HOUSEKEEPING	0	32,699	13,954	46,653	9.00
10.00 01000	DIETARY	0	73,386	31,317	104,703	10.00
11.00 01100	CAFETERIA	0	27,702	11,822	39,524	11.00
13.00 01300	NURSING ADMINISTRATION	0	69,884	29,823	99,707	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	131,347	56,052	187,399	14.00
15.00 01500	PHARMACY	0	131,740	56,220	187,960	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	49,068	20,940	70,008	16.00
17.00 01700	SOCIAL SERVICE	0	31,046	13,249	44,295	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	891,685	380,527	1,272,212	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	16,448	7,019	23,467	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	31,991	13,652	45,643	54.00
60.00 06000	LABORATORY	0	39,113	16,691	55,804	60.00
65.00 06500	RESPIRATORY THERAPY	0	50,367	21,494	71,861	65.00
66.00 06600	PHYSICAL THERAPY	0	37,381	15,953	53,334	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	30,299	12,930	43,229	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)	207,045	2,158,879	921,302	3,287,226	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	NONALLOWABLE CLINICAL LIAISON	0	0	0	0	194.00
194.01 07951	IDLE SPACE	0	0	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 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	0	0	0	194.09
194.10 07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11 07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	207,045	2,158,879	921,302	3,287,226	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet B Part II Date/Time Prepared: 1/12/2017 11:54 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	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	706,918				5.00	
7.00	00700	OPERATION OF PLANT	41,924	202,600			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	4,992	5,587	77,106		8.00	
9.00	00900	HOUSEKEEPING	13,622	3,918	0	64,418	9.00	
10.00	01000	DIETARY	20,031	8,794	0	2,934	136,516	10.00
11.00	01100	CAFETERIA	1,206	3,319	0	1,107	38,094	11.00
13.00	01300	NURSING ADMINISTRATION	46,858	8,374	0	2,794	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,692	15,739	0	5,251	0	14.00
15.00	01500	PHARMACY	39,678	15,786	0	5,266	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,566	5,880	0	1,961	0	16.00
17.00	01700	SOCIAL SERVICE	25,849	3,720	0	1,241	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	269,358	106,847	77,106	35,645	98,422	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	10,744	1,971	0	658	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,792	3,833	0	1,279	0	54.00
60.00	06000	LABORATORY	15,326	4,687	0	1,564	0	60.00
65.00	06500	RESPIRATORY THERAPY	51,338	6,035	0	2,013	0	65.00
66.00	06600	PHYSICAL THERAPY	33,886	4,479	0	1,494	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	33,524	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,860	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	13,470	3,631	0	1,211	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)	706,716	202,600	77,106	64,418	136,516	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	202	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	0	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)	706,918	202,600	77,106	64,418	136,516	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 262010

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

Worksheet B
Part II
Date/Time Prepared:
1/12/2017 11:54 am

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	83,250					11.00
13.00	01300	8,325	167,129				13.00
14.00	01400	1,784	0	219,952			14.00
15.00	01500	0	0	2,677	251,367		15.00
16.00	01600	4,162	0	88	0	102,025	16.00
17.00	01700	4,757	0	84	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	48,167	163,102	5,701	157	39,021	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	1,189	4,027	0	0	412	50.00
54.00	05400	595	0	237	0	1,947	54.00
60.00	06000	1,189	0	0	0	9,050	60.00
65.00	06500	13,082	0	1,422	0	23,578	65.00
66.00	06600	0	0	809	0	4,794	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	208,934	0	3,452	71.00
73.00	07300	0	0	0	251,210	18,320	73.00
74.00	07400	0	0	0	0	1,451	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		83,250	167,129	219,952	251,367	102,025	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		83,250	167,129	219,952	251,367	102,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 262010

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

Worksheet B
Part II
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	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	80,518			17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	80,518	2,199,800	0	2,199,800	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	42,619	0	42,619	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,389	0	64,389	54.00
60.00	06000	LABORATORY	0	87,693	0	87,693	60.00
65.00	06500	RESPIRATORY THERAPY	0	170,430	0	170,430	65.00
66.00	06600	PHYSICAL THERAPY	0	98,796	0	98,796	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	245,910	0	245,910	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	314,390	0	314,390	73.00
74.00	07400	RENAL DIALYSIS	0	62,992	0	62,992	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)	80,518	3,287,019	0	3,287,019	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	207	0	207	194.00
194.01	07951	IDLE SPACE	0	0	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 ADMINISTRATION DEPT	0	0	0	0	194.07
194.08	07959	OTHER NONREIMBURSABLE - OPEN	0	0	0	0	194.08
194.09	07958	VISITOR MEALS	0	0	0	0	194.09
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.10
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	80,518	3,287,226	0	3,287,226	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

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

Worksheet B-1

Date/Time Prepared:
1/12/2017 11:54 am

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	54,865				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		54,865			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	156	156	9,793,161		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,878	8,878	1,624,480	-7,284,553	5.00
7.00	00700	OPERATION OF PLANT	2,862	2,862	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,185	1,185	0	0	8.00
9.00	00900	HOUSEKEEPING	831	831	251,522	0	9.00
10.00	01000	DIETARY	1,865	1,865	59,984	0	10.00
11.00	01100	CAFETERIA	704	704	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,776	1,776	1,197,501	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,338	3,338	97,129	0	14.00
15.00	01500	PHARMACY	3,348	3,348	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	1,247	402,808	0	16.00
17.00	01700	SOCIAL SERVICE	789	789	640,208	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,661	22,661	3,961,639	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	418	418	169,065	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	813	813	70,616	0	54.00
60.00	06000	LABORATORY	994	994	81,170	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,280	1,280	1,231,702	0	65.00
66.00	06600	PHYSICAL THERAPY	950	950	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	770	770	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)	54,865	54,865	9,787,824	-7,284,553	23,158,871
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	NONALLOWABLE CLINICAL LIAISON	0	0	5,337	0	194.00
194.01	07951	IDLE SPACE	0	0	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					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,158,879	921,302	1,750,535		7,284,553
203.00		Unit cost multiplier (Wkst. B, Part I)	39.348929	16.792163	0.178751		0.314457
204.00		Cost to be allocated (per Wkst. B, Part II)			8,758		706,918
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000894		0.030516

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

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

Worksheet B-1

Date/Time Prepared:
1/12/2017 11:54 am

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	42,969				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,185	17,995			8.00
9.00	00900	HOUSEKEEPING	831	0	40,953		9.00
10.00	01000	DIETARY	1,865	0	1,865	15,664	10.00
11.00	01100	CAFETERIA	704	0	704	4,371	140
13.00	01300	NURSING ADMINISTRATION	1,776	0	1,776	0	14
14.00	01400	CENTRAL SERVICES & SUPPLY	3,338	0	3,338	0	3
15.00	01500	PHARMACY	3,348	0	3,348	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	0	1,247	0	7
17.00	01700	SOCIAL SERVICE	789	0	789	0	8
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,661	17,995	22,661	11,293	81
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	418	0	418	0	2
54.00	05400	RADIOLOGY-DIAGNOSTIC	813	0	813	0	1
60.00	06000	LABORATORY	994	0	994	0	2
65.00	06500	RESPIRATORY THERAPY	1,280	0	1,280	0	22
66.00	06600	PHYSICAL THERAPY	950	0	950	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	770	0	770	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)	42,969	17,995	40,953	15,664	140
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	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	0	0
194.10	07962	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.11	07961	NONREIMB NEW BUSINESS IMPLEMENTATION	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,805,848	264,833	621,679	969,527	362,771
203.00		Unit cost multiplier (Wkst. B, Part I)	42.026763	14.717033	15.180304	61.895237	2,591.221429
204.00		Cost to be allocated (per Wkst. B, Part II)	202,600	77,106	64,418	136,516	83,250
205.00		Unit cost multiplier (Wkst. B, Part II)	4.715027	4.284857	1.572974	8.715271	594.642857

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 262010

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

Worksheet B-1
Date/Time Prepared:
1/12/2017 11:54 am

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	83					13.00
14.00	01400	0	1,156,524				14.00
15.00	01500	0	14,076	1,470,962			15.00
16.00	01600	0	463	0	115,708,352		16.00
17.00	01700	0	444	0	0	17,995	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	81	29,978	917	44,276,036	17,995	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	2	0	0	466,997	0	50.00
54.00	05400	0	1,248	0	2,207,301	0	54.00
60.00	06000	0	0	0	10,260,913	0	60.00
65.00	06500	0	7,478	0	26,732,806	0	65.00
66.00	06600	0	4,254	0	5,434,938	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	1,098,583	0	3,913,770	0	71.00
73.00	07300	0	0	1,470,045	20,770,768	0	73.00
74.00	07400	0	0	0	1,644,823	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		83	1,156,524	1,470,962	115,708,352	17,995	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		2,156,255	616,197	1,908,142	932,523	1,179,547	202.00
203.00		25,978.975904	0.532801	1.297207	0.008059	65.548597	203.00
204.00		167,129	219,952	251,367	102,025	80,518	204.00
205.00		2,013.602410	0.190184	0.170886	0.000882	4.474465	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/12/2017 11:54 am

		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	17,730,308		17,730,308	135,960	17,866,268	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	547,593		547,593	0	547,593	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	532,406		532,406	0	532,406	54.00
60.00	06000 LABORATORY	804,890		804,890	0	804,890	60.00
65.00	06500 RESPIRATORY THERAPY	2,561,025	0	2,561,025	0	2,561,025	65.00
66.00	06600 PHYSICAL THERAPY	1,560,049	0	1,560,049	0	1,560,049	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	2,060,906		2,060,906	0	2,060,906	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,006,655		4,006,655	0	4,006,655	73.00
74.00	07400 RENAL DIALYSIS	637,511		637,511	1,054	638,565	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	30,441,343	0	30,441,343	137,014	30,578,357	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	30,441,343	0	30,441,343	137,014	30,578,357	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	44,276,036		44,276,036		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	466,997	0	466,997	1.172584	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,207,301	0	2,207,301	0.241202	54.00
60.00	06000	LABORATORY	10,260,913	0	10,260,913	0.078442	60.00
65.00	06500	RESPIRATORY THERAPY	26,732,806	0	26,732,806	0.095801	65.00
66.00	06600	PHYSICAL THERAPY	5,434,938	0	5,434,938	0.287041	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	3,913,770	0	3,913,770	0.526578	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,770,768	0	20,770,768	0.192899	73.00
74.00	07400	RENAL DIALYSIS	1,644,823	0	1,644,823	0.387586	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)	115,708,352	0	115,708,352		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	115,708,352	0	115,708,352		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet C Part I Date/Time Prepared: 1/12/2017 11:54 am
		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	1.172584		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.241202		54.00
60.00	06000 LABORATORY	0.078442		60.00
65.00	06500 RESPIRATORY THERAPY	0.095801		65.00
66.00	06600 PHYSICAL THERAPY	0.287041		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	0.526578		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.192899		73.00
74.00	07400 RENAL DIALYSIS	0.388227		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: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	17,730,308		17,730,308	135,960	17,866,268	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	547,593		547,593	0	547,593	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	532,406		532,406	0	532,406	54.00
60.00	06000 LABORATORY	804,890		804,890	0	804,890	60.00
65.00	06500 RESPIRATORY THERAPY	2,561,025	0	2,561,025	0	2,561,025	65.00
66.00	06600 PHYSICAL THERAPY	1,560,049	0	1,560,049	0	1,560,049	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	2,060,906		2,060,906	0	2,060,906	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,006,655		4,006,655	0	4,006,655	73.00
74.00	07400 RENAL DIALYSIS	637,511		637,511	1,054	638,565	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
200.00	Subtotal (see instructions)	30,441,343	0	30,441,343	137,014	30,578,357	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	30,441,343	0	30,441,343	137,014	30,578,357	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/12/2017 11:54 am

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	44,276,036		44,276,036		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	466,997	0	466,997	1.172584	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,207,301	0	2,207,301	0.241202	54.00
60.00	06000	LABORATORY	10,260,913	0	10,260,913	0.078442	60.00
65.00	06500	RESPIRATORY THERAPY	26,732,806	0	26,732,806	0.095801	65.00
66.00	06600	PHYSICAL THERAPY	5,434,938	0	5,434,938	0.287041	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	3,913,770	0	3,913,770	0.526578	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,770,768	0	20,770,768	0.192899	73.00
74.00	07400	RENAL DIALYSIS	1,644,823	0	1,644,823	0.387586	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)	115,708,352	0	115,708,352		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	115,708,352	0	115,708,352		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 262010

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

Worksheet C
Part I
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
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: 262010		Period: From 09/01/2015 To 08/31/2016		Worksheet D Part I Date/Time Prepared: 1/12/2017 11:54 am	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,199,800	0	2,199,800	17,995	122.25	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)	2,199,800		2,199,800	17,995		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	10,093	1,233,869				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	10,093	1,233,869				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part II Date/Time Prepared: 1/12/2017 11:54 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	42,619	466,997	0.091262	304,429	27,783	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	64,389	2,207,301	0.029171	1,220,702	35,609	54.00
60.00	06000 LABORATORY	87,693	10,260,913	0.008546	5,885,316	50,296	60.00
65.00	06500 RESPIRATORY THERAPY	170,430	26,732,806	0.006375	15,020,995	95,759	65.00
66.00	06600 PHYSICAL THERAPY	98,796	5,434,938	0.018178	3,110,569	56,544	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	245,910	3,913,770	0.062832	2,335,337	146,734	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	314,390	20,770,768	0.015136	11,768,185	178,123	73.00
74.00	07400 RENAL DIALYSIS	62,992	1,644,823	0.038297	870,353	33,332	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)	1,087,219	71,432,316		40,515,886	624,180	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 262010		Period: From 09/01/2015 To 08/31/2016		Worksheet D Part III Date/Time Prepared: 1/12/2017 11:54 am	
Cost Center Description			Title XVIII		Hospital		PPS	
			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	17,995	0.00	10,093	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)	17,995		10,093	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 262010

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

Worksheet D
Part IV
Date/Time Prepared:
1/12/2017 11:54 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part IV Date/Time Prepared: 1/12/2017 11:54 am
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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	466,997	0.000000	0.000000	304,429	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,207,301	0.000000	0.000000	1,220,702	54.00
60.00	06000 LABORATORY	0	10,260,913	0.000000	0.000000	5,885,316	60.00
65.00	06500 RESPIRATORY THERAPY	0	26,732,806	0.000000	0.000000	15,020,995	65.00
66.00	06600 PHYSICAL THERAPY	0	5,434,938	0.000000	0.000000	3,110,569	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	3,913,770	0.000000	0.000000	2,335,337	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	20,770,768	0.000000	0.000000	11,768,185	73.00
74.00	07400 RENAL DIALYSIS	0	1,644,823	0.000000	0.000000	870,353	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	71,432,316			40,515,886	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 262010

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

Worksheet D
Part IV
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Cost Center Description		Title XVIII			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
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: 262010

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

Worksheet D
Part V
Date/Time Prepared:
1/12/2017 11:54 am

		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	1.172584	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241202	0	43,669	0	0	54.00
60.00	06000	LABORATORY	0.078442	0	1,224	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.095801	0	74,855	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.287041	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	0.526578	0	2,369	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.192899	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.387586	0	57,270	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	179,387	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	179,387	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet D Part V Date/Time Prepared: 1/12/2017 11:54 am
	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	10,533	0	54.00
60.00	06000 LABORATORY	96	0	60.00
65.00	06500 RESPIRATORY THERAPY	7,171	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	1,247	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	22,197	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)	41,244	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	41,244	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/12/2017 11:54 am
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)		17,995	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,995	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)		17,995	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)		10,093	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)		17,866,268	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)		17,866,268	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)		17,866,268	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)		992.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,020,835	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)		10,020,835	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/12/2017 11:54 am
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)					7,282,651
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					17,303,486
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,233,869
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					624,180
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,858,049
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,445,437
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: 262010		Period: From 09/01/2015 To 08/31/2016		Worksheet D-1 Date/Time Prepared: 1/12/2017 11:54 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,199,800	17,866,268	0.123126	0	0	90.00
91.00	Nursing School cost	0	17,866,268	0.000000	0	0	91.00
92.00	Allied health cost	0	17,866,268	0.000000	0	0	92.00
93.00	All other Medical Education	0	17,866,268	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/12/2017 11:54 am
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)		17,995	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,995	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)		17,995	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)		2,962	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)		17,730,308	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)		17,730,308	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)		17,730,308	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)		985.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,918,429	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,918,429	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet D-1 Date/Time Prepared: 1/12/2017 11:54 am
Cost Center Description			Title XIX	Hospital	Cost
	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	0	0	0.00	0	0
44.00					43.00
45.00					44.00
46.00					45.00
47.00					46.00
OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,918,429
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: 262010		Period: From 09/01/2015 To 08/31/2016		Worksheet D-1 Date/Time Prepared: 1/12/2017 11:54 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,199,800	17,730,308	0.124070	0	0	90.00
91.00	Nursing School cost	0	17,730,308	0.000000	0	0	91.00
92.00	Allied health cost	0	17,730,308	0.000000	0	0	92.00
93.00	All other Medical Education	0	17,730,308	0.000000	0	0	93.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 262010

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

Worksheet D-2

Date/Time Prepared:
1/12/2017 11:54 am

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																																																																																																																																				
1.00	Total cost of services rendered					1.00																																																																																																																														
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2.00	0.00	0	17,995	0.00	0	2.00																																																																																																																														
3.00	0.00	0	0	0.00	0	3.00																																																																																																																														
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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)																																																																																																																															
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APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 262010

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

Worksheet D-2

Date/Time Prepared:
1/12/2017 11:54 am

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: 262010

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

Worksheet D-2
Date/Time Prepared:
1/12/2017 11:54 am

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	10,093	2,962	0	0	2.00
3.00	INTENSIVE CARE UNIT	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	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	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	23.00
24.00	EMERGENCY	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	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: 262010

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

Worksheet D-2

Date/Time Prepared:
1/12/2017 11:54 am

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: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet D-3 Date/Time Prepared: 1/12/2017 11:54 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		24,674,140		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1.172584	304,429	356,969	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.241202	1,220,702	294,436	54.00
60.00	06000 LABORATORY	0.078442	5,885,316	461,656	60.00
65.00	06500 RESPIRATORY THERAPY	0.095801	15,020,995	1,439,026	65.00
66.00	06600 PHYSICAL THERAPY	0.287041	3,110,569	892,861	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	0.526578	2,335,337	1,229,737	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.192899	11,768,185	2,270,071	73.00
74.00	07400 RENAL DIALYSIS	0.388227	870,353	337,895	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)		40,515,886	7,282,651	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		40,515,886		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet E Part B Date/Time Prepared: 1/12/2017 11:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		41,244	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)		41,244	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		179,387	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)		179,387	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)		179,387	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		138,143	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)		41,244	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)		35,877	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)		5,367	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		5,367	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,367	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		5,367	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,367	40.00
40.01	Sequestration adjustment (see instructions)		107	40.01
41.00	Interim payments		10,217	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-4,957	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: 262010		Period: From 09/01/2015 To 08/31/2016		Worksheet E-1 Part I Date/Time Prepared: 1/12/2017 11:54 am	
		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		16,725,838		10,217	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	11/23/2015	131,400		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	11/30/2016	1,064,100		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)		-932,700		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)		15,793,138		10,217	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		31,160		4,957	6.02	
7.00	Total Medicare program liability (see instructions)		15,761,978		5,260	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: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part IV Date/Time Prepared: 1/12/2017 11:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		15,672,750	1.00
2.00	Outlier Payments		1,151,215	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		16,823,965	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)		16,823,965	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		16,823,965	9.00
10.00	Deductibles		38,192	10.00
11.00	Subtotal (line 9 minus line 10)		16,785,773	11.00
12.00	Coinsurance		1,105,769	12.00
13.00	Subtotal (line 11 minus line 12)		15,680,004	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		620,996	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		403,647	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		381,111	16.00
17.00	Subtotal (sum of lines 13 and 15)		16,083,651	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)		16,083,651	22.00
22.01	Sequestration adjustment (see instructions)		321,673	22.01
23.00	Interim payments		15,793,138	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)		-31,160	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: 262010	Period: From 09/01/2015 To 08/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 1/12/2017 11:54 am	
		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		2,918,429		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)		2,918,429	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)		2,918,429	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	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)		0	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)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		2,918,429	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)		0	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)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		2,918,429	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	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)		0	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)		0	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)		0	0	40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	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: 262010

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

Worksheet G

Date/Time Prepared:
1/12/2017 11:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	102,351	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	3,840,605	0	0	0	4.00
5.00	Other receivable	-10,368	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-725,307	0	0	0	6.00
7.00	Inventory	320,720	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,528,001	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,006,630	0	0	0	17.00
18.00	Accumulated depreciation	-1,449,033	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	5,719,579	0	0	0	23.00
24.00	Accumulated depreciation	-4,679,453	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)	2,597,723	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	20,533	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	20,533	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	6,146,257	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,141,897	0	0	0	37.00
38.00	Salaries, wages, and fees payable	743,429	0	0	0	38.00
39.00	Payroll taxes payable	8,101	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	270,777	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,164,204	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	-30,769,706	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-30,769,706	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-28,605,502	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	34,751,759				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)	34,751,759	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,146,257	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 262010

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

Worksheet G-1

Date/Time Prepared:
1/12/2017 11:54 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		34,241,673		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		510,086			2.00
3.00	Total (sum of line 1 and line 2)		34,751,759		0	3.00
4.00	Additions (credit adjustments)	0		0		4.00
5.00	INTERCOMPANY TRANSFERS\ROUNDING	0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		34,751,759		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)		34,751,759		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: 262010

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
1/12/2017 11:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	44,276,036		44,276,036	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)	44,276,036		44,276,036	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)	44,276,036		44,276,036	17.00
18.00	Ancillary services	71,432,316	0	71,432,316	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)	115,708,352	0	115,708,352	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,355,421		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)		30,355,421		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 262010

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

Worksheet G-3

Date/Time Prepared:
1/12/2017 11:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	115,708,352	1.00
2.00	Less contractual allowances and discounts on patients' accounts	84,872,374	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,835,978	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,355,421	4.00
5.00	Net income from service to patients (line 3 minus line 4)	480,557	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	4,090	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	-50	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	3,285	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	1,515	21.00
22.00	Rental of hospital space	2,539	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	18,150	24.00
25.00	Total other income (sum of lines 6-24)	29,529	25.00
26.00	Total (line 5 plus line 25)	510,086	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)	510,086	29.00