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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/28/2017 1:36 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/28/2017 Time: 1:36 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 BLUFFTON REGIONAL MEDICAL CENTER (15-0075) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/28/2017 Time: 1:36 pm
VACRzDL8g6r2eFGvMdlDdmy5ceYNb0
pW3pR0:WxNf6Ux5oLj49uTwyNJoY3n
:W6418iBYO0vaHz2

PI: Date: 2/28/2017 Time: 1:36 pm
tHNNfF8Amr5QpGzLLATgOFI114jCC0
3su4B0Sss2GYRJX6FWGxTaA1lBGunE
Z15j0Psbx.0it0km

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

Senior Vice President, Revenue Management
Title

2/28/2017
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	125,569	37,896	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	125,569	37,896	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: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2017 1:33 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 S. MAIN STREET	PO Box:			1.00
2.00	City: BLUFFTON	State: IN	Zip Code: 46714-	County: WELLS	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		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	BLUFFTON REGIONAL MEDICAL CENTER	150075	23060	1	07/01/1966	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	BLUFFTON SKILLED NURSING	155373	23060		03/13/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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)	10/01/2015	09/30/2016	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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	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.	110	121	0	0	953	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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2017 1:33 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			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)	Y	Y	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	Y	40.00

		V	XVIII	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	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	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	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/28/2017 1:33 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2017 1:33 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2017 1:33 pm

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	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. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				N	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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	17,014	187,001	76,844	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		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: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/28/2017 1:33 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	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: CHS / COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	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	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus 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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	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)	9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/28/2017 1:33 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2016	03/30/2016	170.00
		1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2017 1:33 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/20/2017	Y	01/20/2017	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/28/2017 1:33 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	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.	N	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	12/31/2015	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.	KUZIWA	TSIGA	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3416	KUZIWA_TSIGA@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/28/2017 1:33 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		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: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/28/2017 1:33 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P 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	55	20,130	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)		55	20,130	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,562	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	43.00				0	13.00
14.00	Total (see instructions)		62	22,692	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	13	4,758		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	89.00				0	26.25
27.00	Total (sum of lines 14-26)		75				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: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2017 1:33 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,777	159	3,663			1.00
2.00	HMO and other (see instructions)	991	953				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			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,777	159	3,663			7.00
8.00	INTENSIVE CARE UNIT	371	6	950			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		66	644			13.00
14.00	Total (see instructions)	2,148	231	5,257	0.00	212.98	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	1,604	0	3,003	0.00	12.56	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	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	225.54	27.00
28.00	Observation Bed Days		0	1,476			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/28/2017 1:33 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	587	249	1,529	1.00
2.00	HMO and other (see instructions)			254	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	587	249	1,529	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	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2017 1:33 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	11,848,027	0	11,848,027	469,129.00	25.26	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	606,605	0	606,605	26,123.00	23.22	9.00
10.00	Excluded area salaries (see instructions)		3,503	70,882	74,385	2,812.00	26.45	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		95,629	0	95,629	1,608.00	59.47	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		105,214	0	105,214	805.00	130.70	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		980,596	0	980,596	28,094.00	34.90	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		2,876,590	0	2,876,590			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		232,633	0	232,633			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	163,382	0	163,382	5,362.00	30.47	26.00
27.00	Administrative & General	5.00	1,567,292	-224,053	1,343,239	56,919.00	23.60	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/28/2017 1:33 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	309,081	0	309,081	13,595.00	22.73	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	206,983	0	206,983	16,657.00	12.43	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	390,924	-192,925	197,999	15,424.13	12.84	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	192,925	192,925	15,028.87	12.84	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	820,885	153,171	974,056	25,872.00	37.65	38.00
39.00	Central Services and Supply	14.00	117,007	0	117,007	7,538.00	15.52	39.00
40.00	Pharmacy	15.00	512,763	0	512,763	13,289.00	38.59	40.00
41.00	Medical Records & Medical Records Library	16.00	293,264	0	293,264	16,567.00	17.70	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 2/28/2017 1:33 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		11,848,027	0	11,848,027	469,129.00	25.26	1.00
2.00	Excluded area salaries (see instructions)		610,108	70,882	680,990	28,935.00	23.54	2.00
3.00	Subtotal salaries (line 1 minus line 2)		11,237,919	-70,882	11,167,037	440,194.00	25.37	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,181,439	0	1,181,439	30,507.00	38.73	4.00
5.00	Subtotal wage-related costs (see inst.)		2,876,590	0	2,876,590	0.00	25.76	5.00
6.00	Total (sum of lines 3 thru 5)		15,295,948	-70,882	15,225,066	470,701.00	32.35	6.00
7.00	Total overhead cost (see instructions)		4,381,581	-70,882	4,310,699	186,252.00	23.14	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 2/28/2017 1:33 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	258,165	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,680,447	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	16,975	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,216	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	411	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	13,282	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	193,891	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	748,801	17.00
18.00	Medicare Taxes - Employers Portion Only	175,123	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	10,912	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,109,223	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 2/28/2017 1:33 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	95,629	3,109,223	1.00
2.00	Hospital	95,629	2,876,590	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	213,770	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	18,863	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-7 | Date/Time Prepared: 2/28/2017 1:33 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	201	0	201	15.00
16.00		RVB	197	0	197	16.00
17.00		RVA	63	0	63	17.00
18.00		RHC	252	0	252	18.00
19.00		RHB	425	0	425	19.00
20.00		RHA	124	0	124	20.00
21.00		RMC	7	0	7	21.00
22.00		RMB	85	0	85	22.00
23.00		RMA	58	0	58	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	13	0	13	31.00
32.00		HD1	6	0	6	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	35	0	35	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	55	0	55	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	20	0	20	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	6	0	6	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	7	0	7	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	7	0	7	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	12	0	12	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	26	0	26	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-7 | Date/Time Prepared: 2/28/2017 1:33 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	5	0	5	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,604	0	1,604	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	23060	23060	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	3,114,990			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/28/2017 1:33 pm

		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)	0.158921	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,208,808	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	27,312,762	6.00
7.00	Medicaid cost (line 1 times line 6)	4,340,571	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)	3,131,763	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (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)	3,343	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	71,102	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	11,300	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)	7,957	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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,139,720	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	332,669	0	332,669	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	52,868	0	52,868	21.00
22.00	Partial payment by patients approved for charity care	15,269	0	15,269	22.00
23.00	Cost of charity care (line 21 minus line 22)	37,599	0	37,599	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	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)	2,863,691	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	53,133	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,810,558	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	446,657	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	484,256	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,623,976	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,024,727	1,024,727	262,235	1,286,962	1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT		0	0	0	0	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,687,531	2,687,531	287,909	2,975,440	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	163,382	108,390	271,772	2,066,028	2,337,800	4.00
5.01	01160	COMMUNICATIONS	0	0	0	585,980	585,980	5.01
5.02	00540	ADMITTING	0	0	0	361,275	361,275	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	1,015,740	1,015,740	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,567,292	8,776,783	10,344,075	-4,577,939	5,766,136	5.04
7.00	00700	OPERATION OF PLANT	309,081	1,572,577	1,881,658	-2,155	1,879,503	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,470	121,470	0	121,470	8.00
9.00	00900	HOUSEKEEPING	206,983	144,115	351,098	-785	350,313	9.00
10.00	01000	DIETARY	390,924	253,072	643,996	-318,430	325,566	10.00
11.00	01100	CAFETERIA	0	0	0	317,223	317,223	11.00
13.00	01300	NURSING ADMINISTRATION	820,885	135,435	956,320	152,450	1,108,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	117,007	1,094,011	1,211,018	-693,261	517,757	14.00
15.00	01500	PHARMACY	512,763	1,321,829	1,834,592	-1,136,431	698,161	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	293,264	220,440	513,704	-5,928	507,776	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,720,255	1,237,858	2,958,113	-608,147	2,349,966	30.00
31.00	03100	INTENSIVE CARE UNIT	674,541	109,423	783,964	-1,333	782,631	31.00
43.00	04300	NURSERY	0	0	0	354,180	354,180	43.00
44.00	04400	SKILLED NURSING FACILITY	606,605	97,501	704,106	-1,814	702,292	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	925,539	1,135,242	2,060,781	-34,895	2,025,886	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	219,471	219,471	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	861,738	235,484	1,097,222	-65,293	1,031,929	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	74,574	81,267	155,841	0	155,841	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	610,926	781,593	1,392,519	-70,226	1,322,293	60.00
65.00	06500	RESPIRATORY THERAPY	351,956	46,755	398,711	-1,170	397,541	65.00
66.00	06600	PHYSICAL THERAPY	690,935	80,734	771,669	-1,979	769,690	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
69.00	06900	ELECTROCARDIOLOGY	165,139	12,510	177,649	0	177,649	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	149,817	149,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	555,630	555,630	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,087,963	1,087,963	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	79,746	14,282	94,028	-935	93,093	76.01
76.03	03953	WOUND CARE	25,310	17,042	42,352	-378	41,974	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	49,472	15,111	64,583	0	64,583	90.00
91.00	09100	EMERGENCY	626,207	370,374	996,581	-2,413	994,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,844,524	21,695,556	33,540,080	-107,611	33,432,469	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,883	22,883	-19	22,864	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	0	0	107,922	107,922	194.01
194.02	07952	SENIOR CIRCLE	3,503	4,999	8,502	-292	8,210	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	11,848,027	21,723,438	33,571,465	0	33,571,465	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-126,954	1,160,008		1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	556	556		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-661,422	2,314,018		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-804	2,336,996		4.00
5.01	01160	COMMUNICATIONS	-26,339	559,641		5.01
5.02	00540	ADMITTING	0	361,275		5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	1,015,740		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	-696,774	5,069,362		5.04
7.00	00700	OPERATION OF PLANT	0	1,879,503		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	121,470		8.00
9.00	00900	HOUSEKEEPING	0	350,313		9.00
10.00	01000	DIETARY	0	325,566		10.00
11.00	01100	CAFETERIA	-42,364	274,859		11.00
13.00	01300	NURSING ADMINISTRATION	-30,401	1,078,369		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	517,757		14.00
15.00	01500	PHARMACY	0	698,161		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-458	507,318		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,349,966		30.00
31.00	03100	INTENSIVE CARE UNIT	0	782,631		31.00
43.00	04300	NURSERY	0	354,180		43.00
44.00	04400	SKILLED NURSING FACILITY	-250	702,042		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-831,536	1,194,350		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	219,471		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,031,929		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	155,841		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	1,322,293		60.00
65.00	06500	RESPIRATORY THERAPY	0	397,541		65.00
66.00	06600	PHYSICAL THERAPY	0	769,690		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	177,649		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	149,817		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	555,630		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,087,963		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	SLEEP LAB	0	93,093		76.01
76.03	03953	WOUND CARE	0	41,974		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	64,583		90.00
91.00	09100	EMERGENCY	-168,063	826,105		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,584,809	30,847,660		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,864		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0		194.00
194.01	07955	MARKETING	0	107,922		194.01
194.02	07952	SENIOR CIRCLE	0	8,210		194.02
194.03	07953	BUSINESS HEALTH	0	0		194.03
194.04	07954	VACANT SPACE	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-2,584,809	30,986,656		200.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/28/2017 1:33 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,068,773	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	2,068,773	
	B - RECLASS OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,782	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	7,782	
	C - RECLASS RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	280,987	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	TOTALS		0	280,987	
	D - RECLASS OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	66,603	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	195,632	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,922	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	269,157	
	E - RECLASS MARKETING DEPT				
1.00	MARKETING	194.01	70,882	37,040	1.00
	TOTALS		70,882	37,040	
	F - RECLASS CNO COSTS				
1.00	NURSING ADMINISTRATION	13.00	153,171	0	1.00
	TOTALS		153,171	0	
	G - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	142,035	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	555,630	2.00
	TOTALS		0	697,665	
	H - RECLASS COST OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,087,963	1.00
	TOTALS		0	1,087,963	
	I - RECLASS LABOR AND DELIVERY COSTS				
1.00	NURSERY	43.00	265,160	89,020	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	164,309	55,162	2.00
	TOTALS		429,469	144,182	
	L - RECLASS A PORTION OF DIETARY TO CAFE				
1.00	CAFETERIA	11.00	192,925	124,298	1.00
	TOTALS		192,925	124,298	
	M - RECLASS ADMIN AND GENERAL COSTS				
1.00	COMMUNICATIONS	5.01	44,765	541,215	1.00
2.00	ADMITTING	5.02	317,449	43,826	2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	96,677	919,063	3.00
	TOTALS		458,891	1,504,104	
500.00	Grand Total: Increases		1,305,338	6,221,951	500.00

RECLASSIFICATIONS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/28/2017 1:33 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2,068,700	0		1.00
2.00	DIETARY	10.00	0	73	0		2.00
	TOTALS		0	2,068,773			
	B - RECLASS OXYGEN						
1.00	OPERATION OF PLANT	7.00	0	190	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,592	0		2.00
	TOTALS		0	7,782			
	C - RECLASS RENTAL AND LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,745	10		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	15,994	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,965	0		3.00
4.00	HOUSEKEEPING	9.00	0	785	0		4.00
5.00	DIETARY	10.00	0	1,134	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	721	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	21,515	0		7.00
8.00	PHARMACY	15.00	0	48,468	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,928	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	34,496	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	1,333	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	1,814	0		12.00
13.00	OPERATING ROOM	50.00	0	1,384	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	65,293	0		14.00
15.00	LABORATORY	60.00	0	70,226	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	1,170	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	1,979	0		17.00
18.00	SLEEP LAB	76.01	0	935	0		18.00
19.00	WOUND CARE	76.03	0	378	0		19.00
20.00	EMERGENCY	91.00	0	2,413	0		20.00
21.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	19	0		21.00
22.00	SENIOR CIRCLE	194.02	0	292	0		22.00
	TOTALS		0	280,987			
	D - RECLASS OTHER CAPITAL COSTS						
1.00		0.00	0	0	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	269,157	0		4.00
	TOTALS		0	269,157			
	E - RECLASS MARKETING DEPT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	70,882	37,040	0		1.00
	TOTALS		70,882	37,040			
	F - RECLASS CNO COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	153,171	0	0		1.00
	TOTALS		153,171	0			
	G - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	664,154	0		1.00
2.00	OPERATING ROOM	50.00	0	33,511	0		2.00
	TOTALS		0	697,665			
	H - RECLASS COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	1,087,963	0		1.00
	TOTALS		0	1,087,963			
	I - RECLASS LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	429,469	144,182	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		429,469	144,182			
	L - RECLASS A PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	192,925	124,298	0		1.00
	TOTALS		192,925	124,298			
	M - RECLASS ADMIN AND GENERAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	458,891	1,504,104	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		458,891	1,504,104			
500.00	Grand Total: Decreases		1,305,338	6,221,951			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/28/2017 1:33 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,844,900	0	0	0	0	1.00
2.00	Land Improvements	748,002	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,419,131	1,765	0	1,765	0	3.00
4.00	Building Improvements	4,917,682	37,647	0	37,647	0	4.00
5.00	Fixed Equipment	4,222,933	0	0	0	242,700	5.00
6.00	Movable Equipment	14,979,871	1,842,916	0	1,842,916	172,732	6.00
7.00	HIT designated Assets	4,206,037	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,338,556	1,882,328	0	1,882,328	415,432	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	54,338,556	1,882,328	0	1,882,328	415,432	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,844,900	0	1.00
2.00	Land Improvements	748,002	0	2.00
3.00	Buildings and Fixtures	21,420,896	0	3.00
4.00	Building Improvements	4,955,329	0	4.00
5.00	Fixed Equipment	3,980,233	0	5.00
6.00	Movable Equipment	16,650,055	0	6.00
7.00	HIT designated Assets	4,206,037	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,805,452	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	55,805,452	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/28/2017 1:33 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,024,727	0	0	0	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,687,531	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,712,258	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,024,727	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,687,531	2.00
3.00	Total (sum of lines 1-2)	0	3,712,258	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/28/2017 1:33 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	39,155,397	0	39,155,397	0.701641	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	16,650,054	0	16,650,054	0.298359	0	2.00
3.00	Total (sum of lines 1-2)	55,805,451	0	55,805,451	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	665,859	0	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	556	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,004,425	280,987	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,670,840	280,987	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	216,889	66,603	195,632	15,025	1,160,008	1.00
1.01	WELLS CRC COSTS-BLDG & FIXT	0	0	0	0	556	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,922	0	21,684	2,314,018	2.00
3.00	Total (sum of lines 1-2)	216,889	73,525	195,632	36,709	3,474,582	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/28/2017 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - WELLS CRC COSTS-BLDG & FIXT (chapter 2)		0	WELLS CRC COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-26,339	COMMUNICATIONS	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-786	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-187,565			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	205,148			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-42,364	CAFETERIA	11.00	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	-458	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-358,868	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26.01	Depreciation - WELLS CRC COSTS-BLDG & FIXT	A	556	WELLS CRC COSTS-BLDG & FIXT	1.01	9	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-683,106	CAP REL COSTS-MVBLE EQUIP	2.00	9	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/28/2017 1:33 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INSERVICE EDUCATION	B	-10,624	NURSING ADMINISTRATION	13.00	0	33.00
33.01	FITNESS REVENUE	B	-239,004	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.01
33.02	OTHER MISC REVENUE	B	-15,212	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.02
33.03	TRAINING REVENUE	A	-2,900	NURSING ADMINISTRATION	13.00	0	33.03
33.04	PATIENT PHONES BENEFITS	A	-804	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING	A	-174,115	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.05
33.06	LOBBYING EXPENSE	A	-4,015	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.06
33.07	PHYSICIAN RECRUITING	A	-45,386	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.07
33.08	CHARITABLE CONTRIBUTIONS	A	-48,770	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.08
33.09	CRNA COSTS	A	-829,161	OPERATING ROOM	50.00	0	33.09
33.10	PROMOTIONAL ITEMS	A	-60	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.10
33.12	COUNTRY CLUB DUES	A	-46,675	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.12
33.13	NON-ALLOWABLE LEGAL (DOJ SETTLEMENT)	A	-74,301	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,584,809				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: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/28/2017 1:33 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOC - CAPITAL-RELAT	216,889	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	9,472	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVABLE	1,486	0	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GEN	PASI OPERATING COSTS	140,869	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BLDG & FIXTURE	5,553	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	76,711	0	4.02
4.03	5.04	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL HOME OFFICE COST	923,364	0	4.03
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	280,859	-186,299	4.04
4.05	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	54,285	110,798	4.05
4.06	5.04	OTHER ADMINISTRATIVE AND GEN	MANAGEMENT FEE	0	903,201	4.06
4.07	5.04	OTHER ADMINISTRATIVE AND GEN	401K FEES	0	6,197	4.07
4.08	5.04	OTHER ADMINISTRATIVE AND GEN	AUDIT FEES	0	24,011	4.08
4.09	5.04	OTHER ADMINISTRATIVE AND GEN	CORPORATE OVERHEAD ALLOCATIO	103,504	548,225	4.09
4.14	5.04	OTHER ADMINISTRATIVE AND GEN	PPSI FEES	0	22,343	4.14
4.17	5.04	OTHER ADMINISTRATIVE AND GEN	PASI COLLECTION FEES	0	168,047	4.17
4.18	5.04	OTHER ADMINISTRATIVE AND GEN	PASI LIEN UNIT	0	11,321	4.18
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,812,992	1,607,844	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		
	Symbol (1)	Name	Percentage of Ownership	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	CHS, INC.	100.00	CHS, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-1 Date/Time Prepared: 2/28/2017 1:33 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	216,889	11		1.00
2.00	9,472	14		2.00
3.00	1,486	14		3.00
4.00	140,869	0		4.00
4.01	5,553	14		4.01
4.02	76,711	14		4.02
4.03	923,364	0		4.03
4.04	467,158	0		4.04
4.05	-56,513	14		4.05
4.06	-903,201	0		4.06
4.07	-6,197	0		4.07
4.08	-24,011	0		4.08
4.09	-444,721	0		4.09
4.14	-22,343	0		4.14
4.17	-168,047	0		4.17
4.18	-11,321	0		4.18
5.00	205,148			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	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/28/2017 1:33 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	42,230	1,605	40,625	159,800	330	1.00
2.00	44.00	SKILLED NURSING FACILITY	250	250	0	0	0	2.00
3.00	50.00	OPERATING ROOM	2,375	2,375	0	0	0	3.00
4.00	91.00	EMERGENCY	168,063	168,063	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			212,918	172,293	40,625		330	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	13.00	NURSING ADMINISTRATION	25,353	1,268	0	0	0	1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			25,353	1,268	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	13.00	NURSING ADMINISTRATION	0	25,353	15,272	16,877		1.00
2.00	44.00	SKILLED NURSING FACILITY	0	0	0	250		2.00
3.00	50.00	OPERATING ROOM	0	0	0	2,375		3.00
4.00	91.00	EMERGENCY	0	0	0	168,063		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	25,353	15,272	187,565		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	WELLS CRC COSTS-BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,160,008	1,160,008				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	556	0	556			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,314,018			2,314,018		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,336,996	0	7	15,569	2,352,572	4.00
5.01	01160	COMMUNICATIONS	559,641	5,823	0	9,994	9,013	5.01
5.02	00540	ADMITTING	361,275	7,719	0	13,248	63,915	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,015,740	11,369	0	19,512	19,465	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,069,362	95,844	4	172,269	178,054	5.04
7.00	00700	OPERATION OF PLANT	1,879,503	67,235	0	115,387	62,230	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	121,470	1,134	13	29,718	0	8.00
9.00	00900	HOUSEKEEPING	350,313	4,790	0	8,220	41,674	9.00
10.00	01000	DIETARY	325,566	47,054	0	80,752	39,865	10.00
11.00	01100	CAFETERIA	274,859	0	16	35,759	38,843	11.00
13.00	01300	NURSING ADMINISTRATION	1,078,369	2,362	0	4,054	196,115	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	517,757	58,340	0	100,122	23,558	14.00
15.00	01500	PHARMACY	698,161	0	0	0	103,239	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	507,318	13,867	0	23,799	59,045	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,349,966	98,519	0	169,076	259,885	30.00
31.00	03100	INTENSIVE CARE UNIT	782,631	17,358	0	29,789	135,811	31.00
43.00	04300	NURSERY	354,180	2,888	0	4,956	53,387	43.00
44.00	04400	SKILLED NURSING FACILITY	702,042	35,242	0	60,481	122,133	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,194,350	92,720	0	159,123	186,347	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	219,471	3,402	0	5,838	33,082	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,031,929	64,548	0	110,775	173,501	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	155,841	4,205	0	7,217	15,015	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,322,293	26,731	0	45,875	123,003	60.00
65.00	06500	RESPIRATORY THERAPY	397,541	31,355	0	53,811	70,862	65.00
66.00	06600	PHYSICAL THERAPY	769,690	29,099	0	49,939	139,112	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
69.00	06900	ELECTROCARDIOLOGY	177,649	0	6	13,136	33,249	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,817	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	555,630	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,087,963	8,652	7	29,698	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	93,093	2,049	0	3,517	16,056	76.01
76.03	03953	WOUND CARE	41,974	0	0	0	5,096	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	64,583	6,343	0	10,886	9,961	90.00
91.00	09100	EMERGENCY	826,105	28,101	0	48,226	126,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,847,660	766,749	53	1,430,746	2,337,596	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,864	5,451	0	9,355	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	353,978	76	772,984	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	20,913	0	35,891	0	194.00
194.01	07955	MARKETING	107,922	12,917	0	22,167	14,271	194.01
194.02	07952	SENIOR CIRCLE	8,210	0	0	0	705	194.02
194.03	07953	BUSINESS HEALTH	0	0	20	42,875	0	194.03
194.04	07954	VACANT SPACE	0	0	407	0	0	194.04
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)	30,986,656	1,160,008	556	2,314,018	2,352,572	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	COMMUNICATIONS	Subtotal	ADMITTING	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS	584,471					5.01
5.02	00540	ADMITTING	9,539	455,696	455,696			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	6,937	1,073,023	16,016	1,089,039	1,089,039	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	45,093	5,560,626	82,988	5,643,614	205,563	5.04
7.00	00700	OPERATION OF PLANT	10,406	2,134,761	31,863	2,166,624	78,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	867	153,202	2,287	155,489	5,664	8.00
9.00	00900	HOUSEKEEPING	1,734	406,731	6,071	412,802	15,037	9.00
10.00	01000	DIETARY	7,805	501,042	7,479	508,521	18,523	10.00
11.00	01100	CAFETERIA	0	349,477	5,216	354,693	12,920	11.00
13.00	01300	NURSING ADMINISTRATION	2,602	1,283,502	19,158	1,302,660	47,451	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,336	704,113	10,510	714,623	26,031	14.00
15.00	01500	PHARMACY	9,539	810,939	12,104	823,043	29,980	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,679	625,708	9,339	635,047	23,132	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,343	2,894,789	43,208	2,937,997	107,019	30.00
31.00	03100	INTENSIVE CARE UNIT	4,336	969,925	14,477	984,402	35,858	31.00
43.00	04300	NURSERY	867	416,278	6,213	422,491	15,390	43.00
44.00	04400	SKILLED NURSING FACILITY	8,672	928,570	13,860	942,430	34,329	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,484	1,662,024	24,807	1,686,831	61,445	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,734	263,527	3,933	267,460	9,742	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,211	1,398,964	20,881	1,419,845	51,719	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	1,734	184,012	2,747	186,759	6,803	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	16,476	1,534,378	22,902	1,557,280	56,725	60.00
65.00	06500	RESPIRATORY THERAPY	2,602	556,171	8,301	564,472	20,561	65.00
66.00	06600	PHYSICAL THERAPY	4,336	992,176	14,809	1,006,985	36,680	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
69.00	06900	ELECTROCARDIOLOGY	5,203	229,243	3,422	232,665	8,475	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	149,817	2,236	152,053	5,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	555,630	8,293	563,923	20,541	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,126,320	16,811	1,143,131	41,640	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	114,715	1,712	116,427	4,241	76.01
76.03	03953	WOUND CARE	0	47,070	703	47,773	1,740	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,336	96,109	1,435	97,544	3,553	90.00
91.00	09100	EMERGENCY	14,742	1,043,254	15,572	1,058,826	38,569	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	250,613	29,221,792	429,353	29,195,449	1,023,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,469	41,139	614	41,753	1,521	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	330,389	1,457,427	21,754	1,479,181	53,881	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	56,804	848	57,652	2,100	194.00
194.01	07955	MARKETING	0	157,277	2,348	159,625	5,815	194.01
194.02	07952	SENIOR CIRCLE	0	8,915	133	9,048	330	194.02
194.03	07953	BUSINESS HEALTH	0	42,895	640	43,535	1,586	194.03
194.04	07954	VACANT SPACE	0	407	6	413	15	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	584,471	30,986,656	455,696	30,986,656	1,089,039	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.03	5.04	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	5,849,177	5,849,177				5.04
7.00	00700	OPERATION OF PLANT	2,245,545	522,509	2,768,054			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	161,153	37,498	41,799	240,450		8.00
9.00	00900	HOUSEKEEPING	427,839	99,553	11,562	0	538,954	9.00
10.00	01000	DIETARY	527,044	122,636	113,579	0	22,549	10.00
11.00	01100	CAFETERIA	367,613	85,539	50,296	0	9,985	11.00
13.00	01300	NURSING ADMINISTRATION	1,350,111	314,153	5,702	24	1,132	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	740,654	172,341	140,822	10,719	27,958	14.00
15.00	01500	PHARMACY	853,023	198,487	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	658,179	153,150	33,473	0	6,646	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,045,016	708,547	237,806	84,637	47,212	30.00
31.00	03100	INTENSIVE CARE UNIT	1,020,260	237,401	41,899	15,244	8,318	31.00
43.00	04300	NURSERY	437,881	101,889	6,971	0	1,384	43.00
44.00	04400	SKILLED NURSING FACILITY	976,759	227,279	85,066	30,516	16,888	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,748,276	406,801	223,807	39,176	44,433	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	277,202	64,501	8,212	0	1,630	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,471,564	342,414	155,805	21,901	30,932	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	193,562	45,039	10,150	0	2,015	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,614,005	375,558	64,523	0	12,810	60.00
65.00	06500	RESPIRATORY THERAPY	585,033	136,130	75,686	1,256	15,026	65.00
66.00	06600	PHYSICAL THERAPY	1,043,665	242,847	70,240	1,568	13,945	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
69.00	06900	ELECTROCARDIOLOGY	241,140	56,110	18,476	0	3,668	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,592	36,670	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	584,464	135,997	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,184,771	275,681	41,770	0	8,293	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	120,668	28,078	4,947	23	982	76.01
76.03	03953	WOUND CARE	49,513	11,521	0	43	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101,097	23,524	15,311	0	3,040	90.00
91.00	09100	EMERGENCY	1,097,395	255,350	67,831	35,343	13,467	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,130,201	5,417,203	1,525,733	240,450	292,313	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,274	10,069	13,158	0	2,612	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,533,062	356,724	1,087,201	0	215,845	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	59,752	13,904	50,481	0	10,022	194.00
194.01	07955	MARKETING	165,440	38,496	31,178	0	6,190	194.01
194.02	07952	SENIOR CIRCLE	9,378	2,182	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	45,121	10,499	60,303	0	11,972	194.03
194.04	07954	VACANT SPACE	428	100	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	30,986,656	5,849,177	2,768,054	240,450	538,954	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	785,808					10.00
11.00	01100	CAFETERIA	0	513,433				11.00
13.00	01300	NURSING ADMINISTRATION	0	38,345	1,709,467			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,158	0	1,103,652		14.00
15.00	01500	PHARMACY	0	19,696	0	37,735	1,108,941	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,536	0	1,367	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	437,654	77,429	481,944	97,940	0	30.00
31.00	03100	INTENSIVE CARE UNIT	69,359	30,177	251,855	19,458	0	31.00
43.00	04300	NURSERY	0	13,193	99,003	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	278,795	38,715	226,489	13,193	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	49,565	345,570	133,028	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,168	61,348	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,140	0	47,677	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	3,267	0	874	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	43,492	0	171,838	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,248	0	11,050	0	65.00
66.00	06600	PHYSICAL THERAPY	0	33,259	0	10,512	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
69.00	06900	ELECTROCARDIOLOGY	0	16,306	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	95,809	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	376,569	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,108,941	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	3,884	0	3,269	0	76.01
76.03	03953	WOUND CARE	0	1,572	9,450	2,040	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,449	0	7,268	0	90.00
91.00	09100	EMERGENCY	0	32,673	233,808	57,205	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	785,808	509,272	1,709,467	1,086,832	1,108,941	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,547	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	0	3,853	0	1,273	0	194.01
194.02	07952	SENIOR CIRCLE	0	308	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	785,808	513,433	1,709,467	1,103,652	1,108,941	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			16.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	877,351					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	58,750	5,276,935	0	5,276,935		30.00
31.00	03100	INTENSIVE CARE UNIT	15,357	1,709,328	0	1,709,328		31.00
43.00	04300	NURSERY	4,880	665,201	0	665,201		43.00
44.00	04400	SKILLED NURSING FACILITY	15,974	1,909,674	0	1,909,674		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	174,014	3,164,670	0	3,164,670		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,024	424,085	0	424,085		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	162,159	2,276,592	0	2,276,592		54.00
54.01	03630	ULTRA SOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	5,451	260,358	0	260,358		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	155,264	2,437,490	0	2,437,490		60.00
65.00	06500	RESPIRATORY THERAPY	19,458	861,887	0	861,887		65.00
66.00	06600	PHYSICAL THERAPY	30,973	1,447,009	0	1,447,009		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	11,123	346,823	0	346,823		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,688	325,759	0	325,759		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,174	1,125,204	0	1,125,204		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,765	2,688,221	0	2,688,221		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0		76.00
76.01	03951	SLEEP LAB	2,893	164,744	0	164,744		76.01
76.03	03953	WOUND CARE	1,778	75,917	0	75,917		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,579	153,268	0	153,268		90.00
91.00	09100	EMERGENCY	82,047	1,875,119	0	1,875,119		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	877,351	27,188,284	0	27,188,284		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	84,660	0	84,660		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,192,832	0	3,192,832		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	134,159	0	134,159		194.00
194.01	07955	MARKETING	0	246,430	0	246,430		194.01
194.02	07952	SENIOR CIRCLE	0	11,868	0	11,868		194.02
194.03	07953	BUSINESS HEALTH	0	127,895	0	127,895		194.03
194.04	07954	VACANT SPACE	0	528	0	528		194.04
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	877,351	30,986,656	0	30,986,656		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS WELLS CRC COSTS-BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7	15,569	15,576	4.00
5.01	01160	COMMUNICATIONS	0	5,823	0	9,994	15,817	5.01
5.02	00540	ADMITTING	0	7,719	0	13,248	20,967	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	11,369	0	19,512	30,881	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	95,844	4	172,269	268,117	5.04
7.00	00700	OPERATION OF PLANT	0	67,235	0	115,387	182,622	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,134	13	29,718	30,865	8.00
9.00	00900	HOUSEKEEPING	0	4,790	0	8,220	13,010	9.00
10.00	01000	DIETARY	0	47,054	0	80,752	127,806	10.00
11.00	01100	CAFETERIA	0	0	16	35,759	35,775	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,362	0	4,054	6,416	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,340	0	100,122	158,462	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,867	0	23,799	37,666	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	98,519	0	169,076	267,595	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,358	0	29,789	47,147	31.00
43.00	04300	NURSERY	0	2,888	0	4,956	7,844	43.00
44.00	04400	SKILLED NURSING FACILITY	0	35,242	0	60,481	95,723	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	92,720	0	159,123	251,843	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,402	0	5,838	9,240	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,548	0	110,775	175,323	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	4,205	0	7,217	11,422	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	26,731	0	45,875	72,606	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,355	0	53,811	85,166	65.00
66.00	06600	PHYSICAL THERAPY	0	29,099	0	49,939	79,038	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
69.00	06900	ELECTROCARDIOLOGY	0	0	6	13,136	13,142	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,652	7	29,698	38,357	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	2,049	0	3,517	5,566	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	6,343	0	10,886	17,229	90.00
91.00	09100	EMERGENCY	0	28,101	0	48,226	76,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	766,749	53	1,430,746	2,197,548	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,451	0	9,355	14,806	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	353,978	76	772,984	1,127,038	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	20,913	0	35,891	56,804	194.00
194.01	07955	MARKETING	0	12,917	0	22,167	35,084	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	20	42,875	42,895	194.03
194.04	07954	VACANT SPACE	0	0	407	0	407	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,160,008	556	2,314,018	3,474,582	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	15,576					4.00
5.01	01160	COMMUNICATIONS	60	15,877				5.01
5.02	00540	ADMITTING	423	259	21,649			5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	129	188	761	31,959		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	1,179	1,225	3,947	6,030	280,498	5.04
7.00	00700	OPERATION OF PLANT	412	283	1,514	2,316	25,058	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24	109	166	1,798	8.00
9.00	00900	HOUSEKEEPING	276	47	288	441	4,774	9.00
10.00	01000	DIETARY	264	212	355	544	5,881	10.00
11.00	01100	CAFETERIA	257	0	248	379	4,102	11.00
13.00	01300	NURSING ADMINISTRATION	1,298	71	910	1,393	15,066	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	156	118	499	764	8,265	14.00
15.00	01500	PHARMACY	684	259	575	880	9,519	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	391	589	444	679	7,345	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,721	471	2,052	3,141	33,967	30.00
31.00	03100	INTENSIVE CARE UNIT	899	118	688	1,052	11,385	31.00
43.00	04300	NURSERY	353	24	295	452	4,886	43.00
44.00	04400	SKILLED NURSING FACILITY	809	236	658	1,007	10,900	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,234	801	1,178	1,803	19,509	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	219	47	187	286	3,093	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,149	495	992	1,518	16,421	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	99	47	130	200	2,160	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	814	448	1,088	1,665	18,011	60.00
65.00	06500	RESPIRATORY THERAPY	469	71	394	603	6,528	65.00
66.00	06600	PHYSICAL THERAPY	921	118	703	1,076	11,646	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
69.00	06900	ELECTROCARDIOLOGY	220	141	163	249	2,691	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	106	163	1,759	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	394	603	6,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	799	1,222	13,221	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	106	0	81	124	1,347	76.01
76.03	03953	WOUND CARE	34	0	33	51	553	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	66	118	68	104	1,128	90.00
91.00	09100	EMERGENCY	835	400	740	1,132	12,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,477	6,810	20,399	30,043	259,781	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	94	29	45	483	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,973	1,033	1,581	17,107	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	40	62	667	194.00
194.01	07955	MARKETING	94	0	112	171	1,846	194.01
194.02	07952	SENIOR CIRCLE	5	0	6	10	105	194.02
194.03	07953	BUSINESS HEALTH	0	0	30	47	504	194.03
194.04	07954	VACANT SPACE	0	0	0	0	5	194.04
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)	15,576	15,877	21,649	31,959	280,498	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	212,205					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,204	36,166				8.00
9.00	00900	HOUSEKEEPING	886	0	19,722			9.00
10.00	01000	DIETARY	8,707	0	825	144,594		10.00
11.00	01100	CAFETERIA	3,856	0	365	0	44,982	11.00
13.00	01300	NURSING ADMINISTRATION	437	4	41	0	3,359	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,796	1,612	1,023	0	978	14.00
15.00	01500	PHARMACY	0	0	0	0	1,726	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,566	0	243	0	2,150	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,231	12,730	1,728	80,531	6,781	30.00
31.00	03100	INTENSIVE CARE UNIT	3,212	2,293	304	12,763	2,644	31.00
43.00	04300	NURSERY	534	0	51	0	1,156	43.00
44.00	04400	SKILLED NURSING FACILITY	6,521	4,590	618	51,300	3,392	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,158	5,893	1,626	0	4,342	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	630	0	60	0	716	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,944	3,294	1,132	0	3,867	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	778	0	74	0	286	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,946	0	469	0	3,810	60.00
65.00	06500	RESPIRATORY THERAPY	5,802	189	550	0	1,599	65.00
66.00	06600	PHYSICAL THERAPY	5,385	236	510	0	2,914	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
69.00	06900	ELECTROCARDIOLOGY	1,416	0	134	0	1,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,202	0	303	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	379	3	36	0	340	76.01
76.03	03953	WOUND CARE	0	6	0	0	138	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,174	0	111	0	127	90.00
91.00	09100	EMERGENCY	5,200	5,316	493	0	2,863	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,964	36,166	10,696	144,594	44,617	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	96	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	83,349	0	7,898	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,870	0	367	0	0	194.00
194.01	07955	MARKETING	2,390	0	227	0	338	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	27	194.02
194.03	07953	BUSINESS HEALTH	4,623	0	438	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	212,205	36,166	19,722	144,594	44,982	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	28,995					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	182,673				14.00
15.00	01500	PHARMACY	0	6,246	19,889			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	226	0	52,299		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,174	16,211	0	3,506	456,839	30.00
31.00	03100	INTENSIVE CARE UNIT	4,272	3,221	0	916	90,914	31.00
43.00	04300	NURSERY	1,679	0	0	291	17,565	43.00
44.00	04400	SKILLED NURSING FACILITY	3,842	2,184	0	953	182,733	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,861	22,018	0	10,331	343,597	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,041	0	0	180	15,699	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,891	0	9,676	233,702	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	145	0	325	15,666	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	28,442	0	9,265	141,564	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,829	0	1,161	104,361	65.00
66.00	06600	PHYSICAL THERAPY	0	1,740	0	1,848	106,135	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
69.00	06900	ELECTROCARDIOLOGY	0	0	0	664	20,249	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,858	0	2,130	20,016	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	62,328	0	1,681	71,528	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	19,889	4,103	81,096	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	541	0	173	8,696	76.01
76.03	03953	WOUND CARE	160	338	0	106	1,419	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,203	0	94	21,422	90.00
91.00	09100	EMERGENCY	3,966	9,468	0	4,896	123,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,995	179,889	19,889	52,299	2,057,083	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,573	0	0	19,135	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,246,979	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	61,810	194.00
194.01	07955	MARKETING	0	211	0	0	40,473	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	153	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	48,537	194.03
194.04	07954	VACANT SPACE	0	0	0	0	412	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,995	182,673	19,889	52,299	3,474,582	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	01160	COMMUNICATIONS				5.01
5.02	00540	ADMITTING				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL				5.04
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
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	456,839		30.00
31.00	03100	INTENSIVE CARE UNIT	0	90,914		31.00
43.00	04300	NURSERY	0	17,565		43.00
44.00	04400	SKILLED NURSING FACILITY	0	182,733		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	343,597		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,699		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	233,702		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	15,666		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	141,564		60.00
65.00	06500	RESPIRATORY THERAPY	0	104,361		65.00
66.00	06600	PHYSICAL THERAPY	0	106,135		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	20,249		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,016		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	71,528		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	81,096		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	SLEEP LAB	0	8,696		76.01
76.03	03953	WOUND CARE	0	1,419		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	21,422		90.00
91.00	09100	EMERGENCY	0	123,882		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,057,083		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,135		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,246,979		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	61,810		194.00
194.01	07955	MARKETING	0	40,473		194.01
194.02	07952	SENIOR CIRCLE	0	153		194.02
194.03	07953	BUSINESS HEALTH	0	48,537		194.03
194.04	07954	VACANT SPACE	0	412		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	3,474,582		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	WELLS CRC COSTS-BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NONPATIENT PHONES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	196,409					1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT	0	119,997				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			228,300			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,536	1,536	11,684,645		4.00
5.01	01160	COMMUNICATIONS	986	0	986	44,765	674	5.01
5.02	00540	ADMITTING	1,307	0	1,307	317,449	11	5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	1,925	0	1,925	96,677	8	5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	16,228	768	16,996	884,348	52	5.04
7.00	00700	OPERATION OF PLANT	11,384	0	11,384	309,081	12	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192	2,740	2,932	0	1	8.00
9.00	00900	HOUSEKEEPING	811	0	811	206,983	2	9.00
10.00	01000	DIETARY	7,967	0	7,967	197,999	9	10.00
11.00	01100	CAFETERIA	0	3,528	3,528	192,925	0	11.00
13.00	01300	NURSING ADMINISTRATION	400	0	400	974,056	3	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,878	0	9,878	117,007	5	14.00
15.00	01500	PHARMACY	0	0	0	512,763	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,348	0	2,348	293,264	25	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,681	0	16,681	1,290,786	20	30.00
31.00	03100	INTENSIVE CARE UNIT	2,939	0	2,939	674,541	5	31.00
43.00	04300	NURSERY	489	0	489	265,160	1	43.00
44.00	04400	SKILLED NURSING FACILITY	5,967	0	5,967	606,605	10	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,699	0	15,699	925,539	34	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	576	0	576	164,309	2	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,929	0	10,929	861,738	21	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	712	0	712	74,574	2	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,526	0	4,526	610,926	19	60.00
65.00	06500	RESPIRATORY THERAPY	5,309	0	5,309	351,956	3	65.00
66.00	06600	PHYSICAL THERAPY	4,927	0	4,927	690,935	5	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
69.00	06900	ELECTROCARDIOLOGY	0	1,296	1,296	165,139	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,465	1,465	2,930	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	347	0	347	79,746	0	76.01
76.03	03953	WOUND CARE	0	0	0	25,310	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,074	0	1,074	49,472	5	90.00
91.00	09100	EMERGENCY	4,758	0	4,758	626,207	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	129,824	11,333	141,157	11,610,260	289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	923	0	923	0	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,934	16,328	76,262	0	381	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	3,541	0	3,541	0	0	194.00
194.01	07955	MARKETING	2,187	0	2,187	70,882	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	3,503	0	194.02
194.03	07953	BUSINESS HEALTH	0	4,230	4,230	0	0	194.03
194.04	07954	VACANT SPACE	0	88,106	0	0	0	194.04
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)	1,160,008	556	2,314,018	2,352,572	584,471	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.906084	0.004633	10.135865	0.201339	867.167656	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				15,576	15,877	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001333	23.556380	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	Reconciliation	ADMITTING (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	
			5A.02	5.02	5A.03	5.03	5A.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING	-455,696	30,530,960				5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	1,073,023	-1,089,039	29,897,617		5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	0	5,560,626	0	5,643,614	-5,849,177	5.04
7.00	00700	OPERATION OF PLANT	0	2,134,761	0	2,166,624	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	153,202	0	155,489	0	8.00
9.00	00900	HOUSEKEEPING	0	406,731	0	412,802	0	9.00
10.00	01000	DIETARY	0	501,042	0	508,521	0	10.00
11.00	01100	CAFETERIA	0	349,477	0	354,693	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,283,502	0	1,302,660	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	704,113	0	714,623	0	14.00
15.00	01500	PHARMACY	0	810,939	0	823,043	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	625,708	0	635,047	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,894,789	0	2,937,997	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	969,925	0	984,402	0	31.00
43.00	04300	NURSERY	0	416,278	0	422,491	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	928,570	0	942,430	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,662,024	0	1,686,831	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	263,527	0	267,460	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,398,964	0	1,419,845	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	184,012	0	186,759	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,534,378	0	1,557,280	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	556,171	0	564,472	0	65.00
66.00	06600	PHYSICAL THERAPY	0	992,176	0	1,006,985	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
69.00	06900	ELECTROCARDIOLOGY	0	229,243	0	232,665	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	149,817	0	152,053	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	555,630	0	563,923	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,126,320	0	1,143,131	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	114,715	0	116,427	0	76.01
76.03	03953	WOUND CARE	0	47,070	0	47,773	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	96,109	0	97,544	0	90.00
91.00	09100	EMERGENCY	0	1,043,254	0	1,058,826	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-455,696	28,766,096	-1,089,039	28,106,410	-5,849,177	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	41,139	0	41,753	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,457,427	0	1,479,181	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	56,804	0	57,652	0	194.00
194.01	07955	MARKETING	0	157,277	0	159,625	0	194.01
194.02	07952	SENIOR CIRCLE	0	8,915	0	9,048	0	194.02
194.03	07953	BUSINESS HEALTH	0	42,895	0	43,535	0	194.03
194.04	07954	VACANT SPACE	0	407	0	413	0	194.04
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)		455,696		1,089,039		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.014926		0.036426		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		21,649		31,959		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000709		0.001069		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.04	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL	25,137,479					5.04
7.00	00700	OPERATION OF PLANT	2,245,545	194,166				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	161,153	2,932	270,767			8.00
9.00	00900	HOUSEKEEPING	427,839	811	0	190,423		9.00
10.00	01000	DIETARY	527,044	7,967	0	7,967	30,669	10.00
11.00	01100	CAFETERIA	367,613	3,528	0	3,528	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,350,111	400	27	400	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	740,654	9,878	12,071	9,878	0	14.00
15.00	01500	PHARMACY	853,023	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	658,179	2,348	0	2,348	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,045,016	16,681	95,308	16,681	17,081	30.00
31.00	03100	INTENSIVE CARE UNIT	1,020,260	2,939	17,166	2,939	2,707	31.00
43.00	04300	NURSERY	437,881	489	0	489	0	43.00
44.00	04400	SKILLED NURSING FACILITY	976,759	5,967	34,364	5,967	10,881	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,748,276	15,699	44,116	15,699	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	277,202	576	0	576	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,471,564	10,929	24,662	10,929	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	193,562	712	0	712	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,614,005	4,526	0	4,526	0	60.00
65.00	06500	RESPIRATORY THERAPY	585,033	5,309	1,414	5,309	0	65.00
66.00	06600	PHYSICAL THERAPY	1,043,665	4,927	1,766	4,927	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
69.00	06900	ELECTROCARDIOLOGY	241,140	1,296	0	1,296	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,592	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	584,464	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,184,771	2,930	0	2,930	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	120,668	347	26	347	0	76.01
76.03	03953	WOUND CARE	49,513	0	48	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	101,097	1,074	0	1,074	0	90.00
91.00	09100	EMERGENCY	1,097,395	4,758	39,799	4,758	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,281,024	107,023	270,767	103,280	30,669	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43,274	923	0	923	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,533,062	76,262	0	76,262	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	59,752	3,541	0	3,541	0	194.00
194.01	07955	MARKETING	165,440	2,187	0	2,187	0	194.01
194.02	07952	SENIOR CIRCLE	9,378	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	45,121	4,230	0	4,230	0	194.03
194.04	07954	VACANT SPACE	428	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,849,177	2,768,054	240,450	538,954	785,808	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.232687	14.256121	0.888033	2.830299	25.622224	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	280,498	212,205	36,166	19,722	144,594	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011159	1.092905	0.133569	0.103569	4.714663	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/28/2017 1:33 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES IN NURSING ARE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (% COSTED R EQUI)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	WELLS CRC COSTS-BLDG & FIXT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00540	ADMITTING						5.02
5.03	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00560	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	16,657					11.00
13.00	01300	NURSING ADMINISTRATION	1,244	4,578,457				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	362	0	1,628,450			14.00
15.00	01500	PHARMACY	639	0	55,679	1,087,963		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	796	0	2,017	0	171,080,443	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,512	1,290,786	144,512	0	11,456,768	30.00
31.00	03100	INTENSIVE CARE UNIT	979	674,541	28,710	0	2,994,642	31.00
43.00	04300	NURSERY	428	265,160	0	0	951,666	43.00
44.00	04400	SKILLED NURSING FACILITY	1,256	606,605	19,467	0	3,114,990	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,608	925,539	196,284	0	33,924,140	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	265	164,309	0	0	589,711	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,432	0	70,348	0	31,622,305	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	106	0	1,289	0	1,063,051	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,411	0	253,549	0	30,277,604	60.00
65.00	06500	RESPIRATORY THERAPY	592	0	16,305	0	3,794,535	65.00
66.00	06600	PHYSICAL THERAPY	1,079	0	15,511	0	6,039,948	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
69.00	06900	ELECTROCARDIOLOGY	529	0	0	0	2,169,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	141,367	0	6,959,491	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	555,630	0	5,494,240	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,087,963	13,409,682	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	126	0	4,823	0	564,077	76.01
76.03	03953	WOUND CARE	51	25,310	3,010	0	346,740	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	47	0	10,724	0	307,905	90.00
91.00	09100	EMERGENCY	1,060	626,207	84,406	0	15,999,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,522	4,578,457	1,603,631	1,087,963	171,080,443	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	22,940	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07955	MARKETING	125	0	1,879	0	0	194.01
194.02	07952	SENIOR CIRCLE	10	0	0	0	0	194.02
194.03	07953	BUSINESS HEALTH	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	513,433	1,709,467	1,103,652	1,108,941	877,351	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.823858	0.373372	0.677732	1.019282	0.005128	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,982	28,995	182,673	19,889	52,299	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.700486	0.006333	0.112176	0.018281	0.000306	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,276,935		5,276,935	0	5,276,935	30.00
31.00	03100	INTENSIVE CARE UNIT	1,709,328		1,709,328	0	1,709,328	31.00
43.00	04300	NURSERY	665,201		665,201	0	665,201	43.00
44.00	04400	SKILLED NURSING FACILITY	1,909,674		1,909,674	0	1,909,674	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,164,670		3,164,670	0	3,164,670	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	424,085		424,085	0	424,085	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,276,592		2,276,592	0	2,276,592	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	260,358		260,358	0	260,358	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,437,490		2,437,490	0	2,437,490	60.00
65.00	06500	RESPIRATORY THERAPY	861,887	0	861,887	0	861,887	65.00
66.00	06600	PHYSICAL THERAPY	1,447,009	0	1,447,009	0	1,447,009	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
69.00	06900	ELECTROCARDIOLOGY	346,823		346,823	0	346,823	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	325,759		325,759	0	325,759	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,125,204		1,125,204	0	1,125,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,688,221		2,688,221	0	2,688,221	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951	SLEEP LAB	164,744		164,744	0	164,744	76.01
76.03	03953	WOUND CARE	75,917		75,917	0	75,917	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	153,268		153,268	0	153,268	90.00
91.00	09100	EMERGENCY	1,875,119		1,875,119	0	1,875,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,515,616		1,515,616		1,515,616	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	28,703,900	0	28,703,900	0	28,703,900	200.00
201.00		Less Observation Beds	1,515,616		1,515,616		1,515,616	201.00
202.00		Total (see instructions)	27,188,284	0	27,188,284	0	27,188,284	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,234,275		9,234,275			30.00
31.00	03100	INTENSIVE CARE UNIT	2,994,642		2,994,642			31.00
43.00	04300	NURSERY	951,666		951,666			43.00
44.00	04400	SKILLED NURSING FACILITY	3,114,990		3,114,990			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,901,922	25,022,218	33,924,140	0.093287	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	424,806	164,905	589,711	0.719140	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,207,001	26,415,304	31,622,305	0.071993	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	154,987	908,064	1,063,051	0.244916	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	8,415,626	21,861,978	30,277,604	0.080505	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,544,002	250,533	3,794,535	0.227139	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,201,426	2,838,522	6,039,948	0.239573	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	823,163	1,345,999	2,169,162	0.159888	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,758,791	3,200,700	6,959,491	0.046808	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,444,776	2,049,464	5,494,240	0.204797	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,564,745	7,844,937	13,409,682	0.200469	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	564,077	564,077	0.292059	0.000000	76.01
76.03	03953	WOUND CARE	0	346,740	346,740	0.218945	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,471	267,434	307,905	0.497777	0.000000	90.00
91.00	09100	EMERGENCY	3,086,926	12,912,860	15,999,786	0.117197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	358,917	1,863,576	2,222,493	0.681944	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	63,223,132	107,857,311	171,080,443			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,223,132	107,857,311	171,080,443			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.093287
51.00	05100	RECOVERY ROOM	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.719140
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071993
54.01	03630	ULTRA SOUND	0.000000
56.00	05600	RADIOISOTOPE	0.244916
57.00	05700	CT SCAN	0.000000
58.00	05800	MRI	0.000000
60.00	06000	LABORATORY	0.080505
65.00	06500	RESPIRATORY THERAPY	0.227139
66.00	06600	PHYSICAL THERAPY	0.239573
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.159888
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.046808
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204797
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200469
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000
76.01	03951	SLEEP LAB	0.292059
76.03	03953	WOUND CARE	0.218945
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.497777
91.00	09100	EMERGENCY	0.117197
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.681944
		OTHER REIMBURSABLE COST CENTERS	
95.00	09500	AMBULANCE SERVICES	0.000000
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/28/2017 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,276,935		5,276,935	0	5,276,935	30.00
31.00	03100	INTENSIVE CARE UNIT	1,709,328		1,709,328	0	1,709,328	31.00
43.00	04300	NURSERY	665,201		665,201	0	665,201	43.00
44.00	04400	SKILLED NURSING FACILITY	1,909,674		1,909,674	0	1,909,674	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,164,670		3,164,670	0	3,164,670	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	424,085		424,085	0	424,085	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,276,592		2,276,592	0	2,276,592	54.00
54.01	03630	ULTRA SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	260,358		260,358	0	260,358	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	2,437,490		2,437,490	0	2,437,490	60.00
65.00	06500	RESPIRATORY THERAPY	861,887	0	861,887	0	861,887	65.00
66.00	06600	PHYSICAL THERAPY	1,447,009	0	1,447,009	0	1,447,009	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
69.00	06900	ELECTROCARDIOLOGY	346,823		346,823	0	346,823	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	325,759		325,759	0	325,759	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,125,204		1,125,204	0	1,125,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,688,221		2,688,221	0	2,688,221	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03951	SLEEP LAB	164,744		164,744	0	164,744	76.01
76.03	03953	WOUND CARE	75,917		75,917	0	75,917	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	153,268		153,268	0	153,268	90.00
91.00	09100	EMERGENCY	1,875,119		1,875,119	0	1,875,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,515,616		1,515,616		1,515,616	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	28,703,900	0	28,703,900	0	28,703,900	200.00
201.00		Less Observation Beds	1,515,616		1,515,616		1,515,616	201.00
202.00		Total (see instructions)	27,188,284	0	27,188,284	0	27,188,284	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/28/2017 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,234,275		9,234,275			30.00
31.00	03100	INTENSIVE CARE UNIT	2,994,642		2,994,642			31.00
43.00	04300	NURSERY	951,666		951,666			43.00
44.00	04400	SKILLED NURSING FACILITY	3,114,990		3,114,990			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,901,922	25,022,218	33,924,140	0.093287	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	424,806	164,905	589,711	0.719140	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,207,001	26,415,304	31,622,305	0.071993	0.000000	54.00
54.01	03630	ULTRA SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	154,987	908,064	1,063,051	0.244916	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	8,415,626	21,861,978	30,277,604	0.080505	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,544,002	250,533	3,794,535	0.227139	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,201,426	2,838,522	6,039,948	0.239573	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	823,163	1,345,999	2,169,162	0.159888	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,758,791	3,200,700	6,959,491	0.046808	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,444,776	2,049,464	5,494,240	0.204797	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,564,745	7,844,937	13,409,682	0.200469	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03951	SLEEP LAB	0	564,077	564,077	0.292059	0.000000	76.01
76.03	03953	WOUND CARE	0	346,740	346,740	0.218945	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,471	267,434	307,905	0.497777	0.000000	90.00
91.00	09100	EMERGENCY	3,086,926	12,912,860	15,999,786	0.117197	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	358,917	1,863,576	2,222,493	0.681944	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	63,223,132	107,857,311	171,080,443			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	63,223,132	107,857,311	171,080,443			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/28/2017 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.01	03951	SLEEP LAB	0.000000		76.01
76.03	03953	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	456,839	0	456,839	5,139	88.90	30.00
31.00	INTENSIVE CARE UNIT	90,914		90,914	950	95.70	31.00
43.00	NURSERY	17,565		17,565	644	27.27	43.00
44.00	SKILLED NURSING FACILITY	182,733		182,733	3,003	60.85	44.00
200.00	Total (lines 30-199)	748,051		748,051	9,736		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,777	157,975				30.00
31.00	INTENSIVE CARE UNIT	371	35,505				31.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	1,604	97,603				44.00
200.00	Total (lines 30-199)	3,752	291,083				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	343,597	33,924,140	0.010128	2,569,263	26,021	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,699	589,711	0.026622	2,799	75	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,702	31,622,305	0.007390	2,057,951	15,208	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	15,666	1,063,051	0.014737	78,136	1,151	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	141,564	30,277,604	0.004676	3,263,499	15,260	60.00
65.00	06500	RESPIRATORY THERAPY	104,361	3,794,535	0.027503	1,412,456	38,847	65.00
66.00	06600	PHYSICAL THERAPY	106,135	6,039,948	0.017572	275,769	4,846	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
69.00	06900	ELECTROCARDIOLOGY	20,249	2,169,162	0.009335	754,032	7,039	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,016	6,959,491	0.002876	1,351,347	3,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	71,528	5,494,240	0.013019	1,929,918	25,126	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,096	13,409,682	0.006048	1,856,422	11,228	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	8,696	564,077	0.015416	0	0	76.01
76.03	03953	WOUND CARE	1,419	346,740	0.004092	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,422	307,905	0.069573	10,186	709	90.00
91.00	09100	EMERGENCY	123,882	15,999,786	0.007743	1,351,190	10,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	131,211	2,222,493	0.059038	193,465	11,422	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,440,243	154,784,870		17,106,433	171,280	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
200.00		Total (lines 30-199)	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	5,139	0.00	1,777	0		30.00
31.00	03100	INTENSIVE CARE UNIT	950	0.00	371	0		31.00
43.00	04300	NURSERY	644	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	3,003	0.00	1,604	0		44.00
200.00		Total (lines 30-199)	9,736		3,752	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		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
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		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	33,924,140	0.000000	0.000000	2,569,263	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	589,711	0.000000	0.000000	2,799	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,622,305	0.000000	0.000000	2,057,951	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	1,063,051	0.000000	0.000000	78,136	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	30,277,604	0.000000	0.000000	3,263,499	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,794,535	0.000000	0.000000	1,412,456	65.00
66.00	06600	PHYSICAL THERAPY	0	6,039,948	0.000000	0.000000	275,769	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
69.00	06900	ELECTROCARDIOLOGY	0	2,169,162	0.000000	0.000000	754,032	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,959,491	0.000000	0.000000	1,351,347	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,494,240	0.000000	0.000000	1,929,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,409,682	0.000000	0.000000	1,856,422	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03951	SLEEP LAB	0	564,077	0.000000	0.000000	0	76.01
76.03	03953	WOUND CARE	0	346,740	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	307,905	0.000000	0.000000	10,186	90.00
91.00	09100	EMERGENCY	0	15,999,786	0.000000	0.000000	1,351,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,222,493	0.000000	0.000000	193,465	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	154,784,870			17,106,433	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,395,264	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,049,972	0		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	356,692	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	2,288,588	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	86,176	0		65.00
66.00	06600	PHYSICAL THERAPY	0	26,959	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	527,696	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	622,794	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	604,137	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,388,679	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03951	SLEEP LAB	0	164,016	0		76.01
76.03	03953	WOUND CARE	0	108,376	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	48,522	0		90.00
91.00	09100	EMERGENCY	0	2,554,513	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	351,532	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	21,573,916	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.093287	5,395,264	0	0	503,308	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.719140	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071993	6,049,972	0	0	435,556	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.244916	356,692	0	0	87,360	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.080505	2,288,588	707	0	184,243	60.00
65.00	06500	RESPIRATORY THERAPY	0.227139	86,176	0	0	19,574	65.00
66.00	06600	PHYSICAL THERAPY	0.239573	26,959	0	0	6,459	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
69.00	06900	ELECTROCARDIOLOGY	0.159888	527,696	0	0	84,372	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.046808	622,794	0	0	29,152	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204797	604,137	0	0	123,725	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200469	2,388,679	0	3,537	478,856	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.292059	164,016	0	0	47,902	76.01
76.03	03953	WOUND CARE	0.218945	108,376	0	0	23,728	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.497777	48,522	0	0	24,153	90.00
91.00	09100	EMERGENCY	0.117197	2,554,513	0	0	299,381	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.681944	351,532	0	0	239,725	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		21,573,916	707	3,537	2,587,494	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		21,573,916	707	3,537	2,587,494	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	57	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	709		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	SLEEP LAB	0	0		76.01
76.03	03953	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	57	709		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	57	709		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0	0	0	0	0	76.01
76.03	03953	WOUND CARE	0	0	0	0	0	76.03
		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
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		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	33,924,140	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	589,711	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,622,305	0.000000	0.000000	35,901	54.00
54.01	03630	ULTRA SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	1,063,051	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	30,277,604	0.000000	0.000000	230,204	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,794,535	0.000000	0.000000	301,504	65.00
66.00	06600	PHYSICAL THERAPY	0	6,039,948	0.000000	0.000000	1,424,160	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
69.00	06900	ELECTROCARDIOLOGY	0	2,169,162	0.000000	0.000000	1,676	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,959,491	0.000000	0.000000	177,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,494,240	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,409,682	0.000000	0.000000	594,341	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0.000000	0	76.00
76.01	03951	SLEEP LAB	0	564,077	0.000000	0.000000	0	76.01
76.03	03953	WOUND CARE	0	346,740	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	307,905	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	15,999,786	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,222,493	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	154,784,870			2,765,243	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	03630	ULTRA SOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
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
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0		76.00
76.01	03951	SLEEP LAB	0	0	0		76.01
76.03	03953	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/28/2017 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.093287	0	144,488	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.719140	0	12,865	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071993	0	367,031	0	0	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.244916	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.080505	0	419,527	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.227139	0	4,374	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.239573	0	92,860	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
69.00	06900	ELECTROCARDIOLOGY	0.159888	0	9,420	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.046808	0	6,787	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204797	0	6,587	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200469	0	64,394	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03951	SLEEP LAB	0.292059	0	8,182	0	0	76.01
76.03	03953	WOUND CARE	0.218945	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.497777	0	5,559	0	0	90.00
91.00	09100	EMERGENCY	0.117197	0	338,704	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.681944	0	25,019	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	1,505,797	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	1,505,797	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/28/2017 1:33 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	13,479	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,252	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,424	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	33,774	0		60.00
65.00	06500	RESPIRATORY THERAPY	994	0		65.00
66.00	06600	PHYSICAL THERAPY	22,247	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,506	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	318	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,349	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,909	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03951	SLEEP LAB	2,390	0		76.01
76.03	03953	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2,767	0		90.00
91.00	09100	EMERGENCY	39,695	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	17,062	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	184,166	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	184,166	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,139	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,139	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.	1,329	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,334	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,777	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)	5,276,935	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)	5,276,935	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	10,185,941	28.00
29.00	Private room charges (excluding swing-bed charges)	2,887,438	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	7,298,503	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.518061	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,172.64	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	3,127.04	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)	5,276,935	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,026.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,824,695	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)	1,824,695	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,709,328	950	1,799.29	371	667,537	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,305,174	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,797,406	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	193,480	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	171,280	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	364,760	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,432,646	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,476	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,026.84	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,515,616	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	456,839	5,276,935	0.086573	1,515,616	131,211	90.00
91.00	Nursing School cost	0	5,276,935	0.000000	1,515,616	0	91.00
92.00	Allied health cost	0	5,276,935	0.000000	1,515,616	0	92.00
93.00	All other Medical Education	0	5,276,935	0.000000	1,515,616	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/28/2017 1:33 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,003	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,003	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.	2,025	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	978	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,604	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)	1,909,674	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,909,674	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	3,114,990	28.00
29.00	Private room charges (excluding swing-bed charges)	2,143,094	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	971,896	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.613059	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,058.32	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	993.76	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	64.56	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	39.58	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	80,150	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,829,524	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	1,829,524	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	609.23	71.00
72.00	Program routine service cost (line 9 x line 71)	977,205	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	977,205	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	977,205	83.00
84.00	Program inpatient ancillary services (see instructions)	558,512	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,535,717	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/28/2017 1:33 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,488,440		30.00
31.00	03100	INTENSIVE CARE UNIT		1,614,752		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093287	2,569,263	239,679	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.719140	2,799	2,013	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071993	2,057,951	148,158	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.244916	78,136	19,137	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.080505	3,263,499	262,728	60.00
65.00	06500	RESPIRATORY THERAPY	0.227139	1,412,456	320,824	65.00
66.00	06600	PHYSICAL THERAPY	0.239573	275,769	66,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.159888	754,032	120,561	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.046808	1,351,347	63,254	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204797	1,929,918	395,241	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200469	1,856,422	372,155	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.292059	0	0	76.01
76.03	03953	WOUND CARE	0.218945	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.497777	10,186	5,070	90.00
91.00	09100	EMERGENCY	0.117197	1,351,190	158,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.681944	193,465	131,932	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		17,106,433	2,305,174	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)		17,106,433		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093287	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.719140	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071993	35,901	2,585	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.244916	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.080505	230,204	18,533	60.00
65.00	06500	RESPIRATORY THERAPY	0.227139	301,504	68,483	65.00
66.00	06600	PHYSICAL THERAPY	0.239573	1,424,160	341,190	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.159888	1,676	268	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.046808	177,457	8,306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200469	594,341	119,147	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.292059	0	0	76.01
76.03	03953	WOUND CARE	0.218945	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.497777	0	0	90.00
91.00	09100	EMERGENCY	0.117197	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.681944	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,765,243	558,512	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)		2,765,243		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/28/2017 1:33 pm

Title XIX | Hospital | Cost

		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		137,664		30.00
31.00	03100	INTENSIVE CARE UNIT		30,342		31.00
43.00	04300	NURSERY		58,673		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.093287	83,556	7,795	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.719140	24,216	17,415	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.071993	37,554	2,704	54.00
54.01	03630	ULTRA SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.244916	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.080505	91,505	7,367	60.00
65.00	06500	RESPIRATORY THERAPY	0.227139	21,454	4,873	65.00
66.00	06600	PHYSICAL THERAPY	0.239573	4,672	1,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.159888	2,388	382	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.046808	23,345	1,093	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.204797	3,973	814	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.200469	56,863	11,399	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03951	SLEEP LAB	0.292059	0	0	76.01
76.03	03953	WOUND CARE	0.218945	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.497777	1,414	704	90.00
91.00	09100	EMERGENCY	0.117197	24,974	2,927	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.681944	9,939	6,778	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		385,853	65,370	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)		385,853		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/28/2017 1:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,300,211	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	3,235	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	1,451,837	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	57.97	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.80	30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.52	31.00
32.00	Sum of lines 30 and 31	25.32	32.00
33.00	Allowable disproportionate share percentage (see instructions)	10.10	33.00
34.00	Disproportionate share adjustment (see instructions)	83,330	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Date/Time Prepared: 2/28/2017 1:33 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000040647	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	260,391	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	260,391	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	260,391		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	3,647,167		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		3,647,167	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		263,037	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment			54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,910,204	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,910,204	61.00
62.00	Deductibles billed to program beneficiaries		550,872	62.00
63.00	Coinsurance billed to program beneficiaries		3,780	63.00
64.00	Allowable bad debts (see instructions)		23,082	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		15,003	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		17,556	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		3,370,555	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		19,389	70.93
70.94	HRR adjustment amount (see instructions)		-60,394	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2016	387,529	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		42,567	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,674,512	71.00
71.01	Sequestration adjustment (see instructions)		73,490	71.01
72.00	Interim payments		3,475,453	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		125,569	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		510,189	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		1.0058751509	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.9817	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2017 1:33 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,300,211	0		3,300,211	3,300,211	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,235	0	0	3,235	3,235	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,451,837	0	0	1,451,837	1,451,837	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1010	0.1010	0.1010	0.1010		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	83,330	0	0	83,330	83,330	11.00
11.01	Uncompensated care payments	36.00	260,391	0	0	260,391	325,109	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,647,167	0	0	3,647,167	3,647,167	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,647,167	0	0	3,647,167	3,647,167	15.00
16.00	Payment for inpatient program capital	50.00	263,037	0	0	263,037	263,037	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/28/2017 1:33 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	0	3,910,204	3,910,204	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	262,217	0	0	262,217	262,217	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	820	0	0	820	820	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	263,037	0	0	263,037	263,037	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.099107		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				387,529	387,529	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/28/2017 1:33 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,300,211		3,300,211	3,300,211	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,235	0	3,235	3,235	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,451,837	0	1,451,837	1,451,837	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1010	0.1010	0.1010		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	83,330	0	83,330	83,330	11.00
11.01	Uncompensated care payments	36.00	260,391	0	260,391	260,391	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,647,167	0	3,647,167	3,647,167	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,647,167	0	3,647,167	3,647,167	15.00
16.00	Payment for inpatient program capital	50.00	263,037	0	263,037	263,037	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,910,204	3,910,204	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/28/2017 1:33 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	262,217	0	262,217	262,217	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	820	0	820	820	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	263,037	0	263,037	263,037	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	387,529		387,529	387,529	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	19,389	0	19,389	19,389	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-60,394	0	-60,394	-60,394	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	42,567	42,567	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/28/2017 1:33 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	766	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,587,494	2.00
3.00	PPS payments	2,336,039	3.00
4.00	Outlier payment (see instructions)	41,013	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)	766	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	4,244	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)	4,244	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 chargebasis 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)	4,244	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,478	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)	766	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)	2,377,052	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,526	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	511,113	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,865,179	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,865,179	30.00
31.00	Primary payer payments	17	31.00
32.00	Subtotal (line 30 minus line 31)	1,865,162	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)	58,661	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	38,130	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	56,610	36.00
37.00	Subtotal (see instructions)	1,903,292	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS PS&R	57,273	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,960,565	40.00
40.01	Sequestration adjustment (see instructions)	39,211	40.01
41.00	Interim payments	1,883,458	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	37,896	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: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,475,453		1,883,458	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,475,453		1,883,458	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		125,569		37,896	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,601,022		1,921,354	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0075 | Component CCN: 15-5373 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/28/2017 1:33 pm

Title XVIII | Skilled Nursing Facility | 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		547,780		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		547,780		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		547,780		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/28/2017 1:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,529	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,148	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	991	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4,613	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	171,080,443	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	332,669	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0075 Component CCN: 15-5373	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 2/28/2017 1:33 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	609,852	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	609,852	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	50,894	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	558,958	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	ROUNDING	1	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	558,959	15.00
15.01	Sequestration adjustment (see instructions)	11,179	15.01
16.00	Interim payments	547,780	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/28/2017 1:33 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-417,067	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	6,113,032	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,358,897	0	0	0	6.00
7.00	Inventory	1,203,178	0	0	0	7.00
8.00	Prepaid expenses	181,261	0	0	0	8.00
9.00	Other current assets	334,038	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)	6,055,545	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,844,900	0	0	0	12.00
13.00	Land improvements	748,002	0	0	0	13.00
14.00	Accumulated depreciation	-422,474	0	0	0	14.00
15.00	Buildings	21,420,896	0	0	0	15.00
16.00	Accumulated depreciation	-9,415,339	0	0	0	16.00
17.00	Leasehold improvements	4,975,804	0	0	0	17.00
18.00	Accumulated depreciation	-3,321,694	0	0	0	18.00
19.00	Fixed equipment	4,027,892	0	0	0	19.00
20.00	Accumulated depreciation	-2,911,786	0	0	0	20.00
21.00	Automobiles and trucks	27,200	0	0	0	21.00
22.00	Accumulated depreciation	-27,200	0	0	0	22.00
23.00	Major movable equipment	10,477,460	0	0	0	23.00
24.00	Accumulated depreciation	-8,386,265	0	0	0	24.00
25.00	Minor equipment depreciable	2,855,990	0	0	0	25.00
26.00	Accumulated depreciation	-2,062,452	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)	21,830,934	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	4,842,953	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,842,953	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,729,432	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,276,759	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,201,123	0	0	0	38.00
39.00	Payroll taxes payable	0	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				42.00
43.00	Due to other funds	25,895,783	0	0	0	43.00
44.00	Other current liabilities	242,055	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,615,720	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,615,720	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,113,712				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)	4,113,712	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,729,432	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/28/2017 1:33 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,994,543		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-880,825				2.00
3.00	Total (sum of line 1 and line 2)		4,113,718		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		4,113,718		0		11.00
12.00	ROUNDING	6		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		6		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,113,712		0		19.00

		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ROUNDING		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/28/2017 1:33 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,185,941		10,185,941	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	3,114,990		3,114,990	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)	13,300,931		13,300,931	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,994,642		2,994,642	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)	2,994,642		2,994,642	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,295,573		16,295,573	17.00
18.00	Ancillary services	46,927,559	0	46,927,559	18.00
19.00	Outpatient services	0	107,857,311	107,857,311	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)	63,223,132	107,857,311	171,080,443	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,571,465		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)		33,571,465		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0075 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/28/2017 1:33 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	171,080,443	1.00
2.00	Less contractual allowances and discounts on patients' accounts	138,716,705	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,363,738	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,571,465	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,207,727	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-1,207,727	26.00
27.00	OTHER	-326,902	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-326,902	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-880,825	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0075	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 2/28/2017 1:33 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	262,217	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	820	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	12.60	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	263,037	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00