Health Financial Systems | REHABILITATION HOSPITAL OF FT WAYNE | In Lieu of Form CMS-2552-10

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: 15-3030	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/22/2017 1:31 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/22/2017 Time: 1:31 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 REHABILITATION HOSPITAL OF FT WAYNE (15-3030) 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: 2/22/2017 Time: 1:31 pm
YOKgPM73MYrwqLVjTizF9LgBeyojs0
u5WUh0pEikAGQVA8m9UTbmWqBP1bio
02C20S46pQ0cRoPV

PI: Date: 2/22/2017 Time: 1:31 pm
HAj4OzqwoQ2GHGCVt6ohBMt1nNAI90
u3s1P0KjdpOrUFq97.QWyASrR2c60x
kfSJ0JOvNa0jX9Vk

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

SRVP Revenue Management
Title

3/22/17
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
	PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	9,466	0	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
200.00	Total	0	9,466	0	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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 1:17 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 7970 WEST JEFFERSON BOULEVARD	PO Box:			1.00
2.00	City: FORT WAYNE	State: IN	Zip Code: 46804-	County: ALLEN	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	REHABILITATION HOSPITAL OF FT WAYNE	153030	23060	5	11/01/1993	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	893	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 1:17 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 1:17 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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 1:17 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.	Y			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)	N	N	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2017 1:17 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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	0	19,606	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/22/2017 1:17 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: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 10301	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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-3030	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part I Date/Time Prepared: 2/22/2017 1:17 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	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)		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 2/22/2017 1:17 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	12/15/2016	Y	12/15/2016	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/22/2017 1:17 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		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		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.	TYLER	LEACH	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-3330	TYLER_LEACH@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-3030	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/22/2017 1:17 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.	REVENUE 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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2017 1:17 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	36	13,176	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)		36	13,176	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		36	13,176	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						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)		36				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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/22/2017 1:17 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)	2,931	893	6,813			1.00
2.00	HMO and other (see instructions)	902	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	2,931	893	6,813			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)	2,931	893	6,813	0.00	90.43	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	90.43	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/22/2017 1:17 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	261	85	637	1.00
2.00	HMO and other (see instructions)			86	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	261	85	637	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/22/2017 1:17 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	NEW CAP REL COSTS-BLDG & FIXT		282,693	282,693	125,753	408,446	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		166,120	166,120	88,182	254,302	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	121,424	29,650	151,074	809,800	960,874	4.00
5.01	00570	ADMITTING	148,336	76,299	224,635	-169	224,466	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	359,646	1,814,127	2,173,773	-1,296,477	877,296	5.02
7.00	00700	OPERATION OF PLANT	187,555	456,495	644,050	-1,997	642,053	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,465	35,465	0	35,465	8.00
9.00	00900	HOUSEKEEPING	92,009	23,427	115,436	-131	115,305	9.00
10.00	01000	DIETARY	308,919	219,119	528,038	-320,175	207,863	10.00
11.00	01100	CAFETERIA	0	0	0	320,175	320,175	11.00
13.00	01300	NURSING ADMINISTRATION	474,717	53,367	528,084	-112	527,972	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	8,151	83,290	91,441	-65,455	25,986	14.00
15.00	01500	PHARMACY	65,321	342,892	408,213	-321,959	86,254	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161,270	72,665	233,935	-2,628	231,307	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,921,778	488,874	2,410,652	312,767	2,723,419	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	28	17,596	17,624	0	17,624	54.00
60.00	06000	LABORATORY	31,675	42,441	74,116	0	74,116	60.00
65.00	06500	RESPIRATORY THERAPY	8,280	17,817	26,097	-10,950	15,147	65.00
66.00	06600	PHYSICAL THERAPY	581,488	64,496	645,984	-20	645,964	66.00
67.00	06700	OCCUPATIONAL THERAPY	777,235	77,202	854,437	0	854,437	67.00
68.00	06800	SPEECH PATHOLOGY	257,866	28,342	286,208	0	286,208	68.00
69.00	06900	ELECTROCARDIOLOGY	321	514	835	0	835	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	17,827	17,827	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	300,257	300,257	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	38,483	3,563	42,046	-26	42,020	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	70,467	70,467	0	70,467	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,544,502	4,466,921	10,011,423	-45,338	9,966,085	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	154	5,639	5,793	178	5,971	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	45,199	45,199	194.01
194.02	07952	TENANT LEASED SPACE	0	39	39	-39	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	5,544,656	4,472,599	10,017,255	0	10,017,255	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-51,203	357,243		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-6,358	247,944		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	960,874		4.00
5.01	00570	ADMITTING	-646	223,820		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	189,213	1,066,509		5.02
7.00	00700	OPERATION OF PLANT	-5,918	636,135		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,799	44,264		8.00
9.00	00900	HOUSEKEEPING	0	115,305		9.00
10.00	01000	DIETARY	0	207,863		10.00
11.00	01100	CAFETERIA	-76,650	243,525		11.00
13.00	01300	NURSING ADMINISTRATION	0	527,972		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	-21,635	4,351		14.00
15.00	01500	PHARMACY	0	86,254		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-30	231,277		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-245,380	2,478,039		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,624		54.00
60.00	06000	LABORATORY	0	74,116		60.00
65.00	06500	RESPIRATORY THERAPY	0	15,147		65.00
66.00	06600	PHYSICAL THERAPY	0	645,964		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	854,437		67.00
68.00	06800	SPEECH PATHOLOGY	0	286,208		68.00
69.00	06900	ELECTROCARDIOLOGY	0	835		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,827		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	300,257		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	42,020		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	70,467		76.01
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-209,808	9,756,277		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,971		192.00
194.00	07950	NON-REIMBURSABLE COST	0	0		194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	45,199		194.01
194.02	07952	TENANT LEASED SPACE	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-209,808	9,807,447		200.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/22/2017 1:17 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	809,916	1.00
2.00	PHYSICAL THERAPY	66.00	0	45	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
	0		0	809,961	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,471	1.00
2.00		0.00	0	0	2.00
	0		0	1,471	
	C - RENTAL AND LEASE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	88,182	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	180	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
	0		0	88,362	
	D - OTHER CAPITAL COSTS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	17,195	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	108,558	2.00
	0		0	125,753	
	E - MARKETING				
1.00	MARKETING/PUBLIC RELATIONS	194.01	30,772	14,427	1.00
	0		30,772	14,427	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16,356	1.00
	0		0	16,356	
	G - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	300,257	1.00
	0		0	300,257	
	H - PHYSICIAN DIRECOTRS				
1.00	ADULTS & PEDIATRICS	30.00	0	313,311	1.00
	TOTALS		0	313,311	
	I - DIETARY				
1.00	CAFETERIA	11.00	182,141	138,034	1.00
	0		182,141	138,034	
500.00	Grand Total: Increases		212,913	1,807,932	500.00

RECLASSIFICATIONS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/22/2017 1:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	809,257	0		1.00
2.00	OPERATION OF PLANT	7.00	0	42	0		2.00
3.00	HOUSEKEEPING	9.00	0	131	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	490	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2	0		5.00
6.00	TENANT LEASED SPACE	194.02	0	39	0		6.00
	0		0	809,961			
	B - OXYGEN COSTS						
1.00	OPERATION OF PLANT	7.00	0	15	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	1,456	0		2.00
	0		0	1,471			
	C - RENTAL AND LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	116	10		1.00
2.00	ADMITTING	5.01	0	169	0		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	2,957	0		3.00
4.00	OPERATION OF PLANT	7.00	0	1,940	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	112	0		5.00
6.00	CENTRAL SERVICE & SUPPLY	14.00	0	49,099	0		6.00
7.00	PHARMACY	15.00	0	21,702	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,628	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	54	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	9,494	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	65	0		11.00
12.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	26	0		12.00
	0		0	88,362			
	D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	125,753	12		1.00
2.00		0.00	0	0	13		2.00
	0		0	125,753			
	E - MARKETING						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	30,772	14,427	0		1.00
	0		30,772	14,427			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	16,356	0		1.00
	0		0	16,356			
	G - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	300,257	0		1.00
	0		0	300,257			
	H - PHYSICIAN DIRECOTRS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	313,311	0		1.00
	TOTALS		0	313,311			
	I - DIETARY						
1.00	DIETARY	10.00	182,141	138,034	0		1.00
	0		182,141	138,034			
500.00	Grand Total: Decreases		212,913	1,807,932			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 2/22/2017 1:17 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	900,000	0	0	0	0	1.00
2.00	Land Improvements	276,744	0	0	0	291	2.00
3.00	Buildings and Fixtures	11,895,304	0	0	0	35,872	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	711,344	33,988	0	33,988	0	6.00
7.00	HIT designated Assets	8,135	0	0	0	420	7.00
8.00	Subtotal (sum of lines 1-7)	13,791,527	33,988	0	33,988	36,583	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,791,527	33,988	0	33,988	36,583	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	900,000	0	1.00
2.00	Land Improvements	276,453	0	2.00
3.00	Buildings and Fixtures	11,859,432	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	745,332	0	6.00
7.00	HIT designated Assets	7,715	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,788,932	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	13,788,932	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/22/2017 1:17 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	NEW CAP REL COSTS-BLDG & FIXT	282,693	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	166,120	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	448,813	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	NEW CAP REL COSTS-BLDG & FIXT	0	282,693	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	166,120	2.00
3.00	Total (sum of lines 1-2)	0	448,813	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 2/22/2017 1:17 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	NEW CAP REL COSTS-BLDG & FIXT	12,135,885	0	12,135,885	0.941574	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	753,047	0	753,047	0.058426	0	2.00
3.00	Total (sum of lines 1-2)	12,888,932	0	12,888,932	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	150,769	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	159,762	88,182	2.00
3.00	Total (sum of lines 1-2)	0	0	0	310,531	88,182	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	NEW CAP REL COSTS-BLDG & FIXT	80,721	17,195	108,558	0	357,243	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	247,944	2.00
3.00	Total (sum of lines 1-2)	80,721	17,195	108,558	0	605,187	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/22/2017 1:17 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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	-2,886	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	7.00
8.00	Television and radio service (chapter 21)	A	-2,620	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-245,380			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	331,086			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-76,650	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-11,938	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	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	-30	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,988	OTHER ADMINISTRATIVE AND GENERAL	5.02	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 - NEW CAP REL COSTS-BLDG & FIXT	A	-121,734	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	-24,098	NEW 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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/22/2017 1:17 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	MISCELANEOUS INCOME	B	-925	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.01	LEGAL FEES	A	-9,055	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.02	MARKETING	A	-2,955	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.02
33.03	PATIENT TELEPHONE EXPENSE	A	-33,934	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.03
33.06	PATIENT TV CABLE EXPENSE	A	-5,918	OPERATION OF PLANT	7.00	0	33.06
33.07	CHARITABLE CONTRIBUTIONS	A	-345	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.07
33.09	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-438	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-209,808				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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/22/2017 1:17 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	NEW CAP REL COSTS-BLDG & FIX	DIRECT ALLOCATION - INTEREST	80,721	0	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	PASI CAPITAL COSTS - BLDG &	67	0	2.00
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	BUILDING AND FIXTURES	1,681	0	3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	MOVABLE EQUIPMENT	23,235	0	4.00
4.01	5.02	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICE ALLOCATION	31,348	0	4.01
4.02	5.02	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE ALLOCATIONS	19,606	91,772	4.02
4.03	8.00	LAUNDRY & LINEN SERVICE	HOSPITAL LAUNDRY SERVICE	44,264	35,465	4.03
4.04	2.00	NEW CAP REL COSTS-MVBLE EQUI	PASI CAPITAL COSTS - MOVEABL	11	0	4.04
4.05	5.01	ADMITTING	PASI OPERATING COSTS	1,007	0	4.05
4.06	5.01	ADMITTING	PASI COLLECTION FEES	0	903	4.06
4.07	5.01	ADMITTING	EBOS FEES	0	44	4.07
4.08	5.01	ADMITTING	PASI LIEN UNIT COLLECTION FE	0	706	4.08
4.09	14.00	CENTRAL SERVICE & SUPPLY	HOSPITAL LAUNDRY SERVICE	0	21,635	4.09
4.10	5.02	OTHER ADMINISTRATIVE AND GEN	NON-CAPITAL ALLOCATIONS	279,671	0	4.10
5.00	0		0	481,611	150,525	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		0.00	COMMUNITY HEALT	100.00	6.00
7.00	B		0.00	LUTHERAN	100.00	7.00
8.00	G	HOSPITAL LAUNDR	100.00	LAUNDRY	100.00	8.00
9.00	B		0.00	PASI	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/22/2017 1:17 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	80,721	11		1.00
2.00	67	9		2.00
3.00	1,681	9		3.00
4.00	23,235	9		4.00
4.01	31,348	0		4.01
4.02	-72,166	0		4.02
4.03	8,799	0		4.03
4.04	11	9		4.04
4.05	1,007	0		4.05
4.06	-903	0		4.06
4.07	-44	0		4.07
4.08	-706	0		4.08
4.09	-21,635	0		4.09
4.10	279,671	0		4.10
5.00	331,086			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	HEALTHCARE		6.00
7.00	HOSPITAL		7.00
8.00	CONSOL LAUNDRY		8.00
9.00	DEBT COLLECTION		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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/22/2017 1:17 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	245,380	245,380	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			245,380	245,380	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	245,380		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		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	0	0	245,380		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS: NEW BLDG & FIXT	CAPITAL RELATED COSTS: NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	357,243	357,243				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	247,944		247,944			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	960,874	1,441	1,232	963,547		4.00
5.01	00570	ADMITTING	223,820	7,423	6,344	26,355	263,942	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,066,509	28,116	24,029	58,431	0	5.02
7.00	00700	OPERATION OF PLANT	636,135	65,443	55,928	33,323	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,264	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	115,305	7,070	6,043	16,347	0	9.00
10.00	01000	DIETARY	207,863	0	0	22,525	0	10.00
11.00	01100	CAFETERIA	243,525	27,316	23,346	32,361	0	11.00
13.00	01300	NURSING ADMINISTRATION	527,972	765	654	84,343	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	4,351	5,400	4,615	1,448	0	14.00
15.00	01500	PHARMACY	86,254	2,288	1,956	11,606	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	231,277	2,623	2,242	28,653	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,700	1,453	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,478,039	45,485	38,874	341,444	89,748	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,624	2,529	2,162	5	2,370	54.00
60.00	06000	LABORATORY	74,116	0	0	5,628	9,969	60.00
65.00	06500	RESPIRATORY THERAPY	15,147	588	503	1,471	379	65.00
66.00	06600	PHYSICAL THERAPY	645,964	59,355	50,728	103,313	42,049	66.00
67.00	06700	OCCUPATIONAL THERAPY	854,437	28,022	23,949	138,091	45,861	67.00
68.00	06800	SPEECH PATHOLOGY	286,208	2,123	1,815	45,815	17,625	68.00
69.00	06900	ELECTROCARDIOLOGY	835	0	0	57	514	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,827	0	0	0	6,769	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	300,257	0	0	0	43,826	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	42,020	2,423	2,071	6,837	2,746	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	70,467	0	0	0	2,086	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,756,277	290,110	247,944	958,053	263,942	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,971	0	0	27	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	45,199	0	0	5,467	0	194.01
194.02	07952	TENANT LEASED SPACE	0	67,133	0	0	0	194.02
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)	9,807,447	357,243	247,944	963,547	263,942	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,177,085	1,177,085				5.02
7.00	00700	OPERATION OF PLANT	790,829	107,860	898,689			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,264	6,037	0	50,301		8.00
9.00	00900	HOUSEKEEPING	144,765	19,744	24,935	0	189,444	9.00
10.00	01000	DIETARY	230,388	31,422	0	0	0	10.00
11.00	01100	CAFETERIA	326,548	44,538	96,337	0	28,651	11.00
13.00	01300	NURSING ADMINISTRATION	613,734	83,707	2,697	0	802	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	15,814	2,157	19,043	0	5,664	14.00
15.00	01500	PHARMACY	102,104	13,926	8,070	0	2,400	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	264,795	36,115	9,252	0	2,752	16.00
17.00	01700	SOCIAL SERVICE	3,153	430	5,995	0	1,783	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,993,590	408,293	160,416	28,216	47,708	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,690	3,367	8,920	0	2,653	54.00
60.00	06000	LABORATORY	89,713	12,236	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,088	2,467	2,074	0	617	65.00
66.00	06600	PHYSICAL THERAPY	901,409	122,942	209,332	10,474	62,254	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,090,360	148,713	98,826	11,611	29,391	67.00
68.00	06800	SPEECH PATHOLOGY	353,586	48,225	7,489	0	2,227	68.00
69.00	06900	ELECTROCARDIOLOGY	1,406	192	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,596	3,355	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	344,083	46,929	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	56,097	7,651	8,547	0	2,542	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	72,553	9,895	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,683,650	1,160,201	661,933	50,301	189,444	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,998	818	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	50,666	6,910	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	67,133	9,156	236,756	0	0	194.02
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)	9,807,447	1,177,085	898,689	50,301	189,444	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	261,810					10.00
11.00	01100	CAFETERIA	0	496,074				11.00
13.00	01300	NURSING ADMINISTRATION	0	50,628	751,568			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	2,103	0	44,781		14.00
15.00	01500	PHARMACY	0	5,608	24,215	0	156,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,862	0	757	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	261,810	244,570	712,413	31,772	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	10	0	0	54.00
60.00	06000	LABORATORY	0	8,023	11,742	65	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,168	3,069	449	0	65.00
66.00	06600	PHYSICAL THERAPY	0	61,143	0	1,693	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	71,424	0	2,135	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	23,990	0	114	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	78	119	4	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,957	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	156,323	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,427	0	95	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	261,810	492,024	751,568	43,041	156,323	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	37	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	4,050	0	1,703	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
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)	261,810	496,074	751,568	44,781	156,323	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333,533					16.00
17.00	01700	SOCIAL SERVICE	0	11,361				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	113,424	11,361	5,013,573	0	5,013,573	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,995	0	42,635	0	42,635	54.00
60.00	06000	LABORATORY	12,597	0	134,376	0	134,376	60.00
65.00	06500	RESPIRATORY THERAPY	479	0	28,411	0	28,411	65.00
66.00	06600	PHYSICAL THERAPY	53,133	0	1,422,380	0	1,422,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,949	0	1,510,409	0	1,510,409	67.00
68.00	06800	SPEECH PATHOLOGY	22,270	0	457,901	0	457,901	68.00
69.00	06900	ELECTROCARDIOLOGY	649	0	2,448	0	2,448	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,553	0	42,461	0	42,461	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,378	0	602,713	0	602,713	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	0	81,829	0	81,829	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	2,636	0	85,084	0	85,084	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	333,533	11,361	9,424,220	0	9,424,220	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,853	0	6,853	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	63,329	0	63,329	194.01
194.02	07952	TENANT LEASED SPACE	0	0	313,045	0	313,045	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	333,533	11,361	9,807,447	0	9,807,447	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,441	1,232	2,673	2,673	4.00
5.01	00570	ADMITTING	0	7,423	6,344	13,767	73	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	28,116	24,029	52,145	162	5.02
7.00	00700	OPERATION OF PLANT	0	65,443	55,928	121,371	92	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,070	6,043	13,113	45	9.00
10.00	01000	DIETARY	0	0	0	0	63	10.00
11.00	01100	CAFETERIA	0	27,316	23,346	50,662	90	11.00
13.00	01300	NURSING ADMINISTRATION	0	765	654	1,419	234	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	5,400	4,615	10,015	4	14.00
15.00	01500	PHARMACY	0	2,288	1,956	4,244	32	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,623	2,242	4,865	80	16.00
17.00	01700	SOCIAL SERVICE	0	1,700	1,453	3,153	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	45,485	38,874	84,359	947	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,529	2,162	4,691	0	54.00
60.00	06000	LABORATORY	0	0	0	0	16	60.00
65.00	06500	RESPIRATORY THERAPY	0	588	503	1,091	4	65.00
66.00	06600	PHYSICAL THERAPY	0	59,355	50,728	110,083	287	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28,022	23,949	51,971	383	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,123	1,815	3,938	127	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,423	2,071	4,494	19	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	290,110	247,944	538,054	2,658	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	0	0	15	194.01
194.02	07952	TENANT LEASED SPACE	0	67,133	0	67,133	0	194.02
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	357,243	247,944	605,187	2,673	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	13,840					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	52,307				5.02
7.00	00700	OPERATION OF PLANT	0	4,793	126,256			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	268	0	268		8.00
9.00	00900	HOUSEKEEPING	0	877	3,503	0	17,538	9.00
10.00	01000	DIETARY	0	1,396	0	0	0	10.00
11.00	01100	CAFETERIA	0	1,979	13,534	0	2,652	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,720	379	0	74	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	96	2,675	0	524	14.00
15.00	01500	PHARMACY	0	619	1,134	0	222	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,605	1,300	0	255	16.00
17.00	01700	SOCIAL SERVICE	0	19	842	0	165	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,714	18,143	22,537	150	4,417	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	124	150	1,253	0	246	54.00
60.00	06000	LABORATORY	522	544	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	20	110	291	0	57	65.00
66.00	06600	PHYSICAL THERAPY	2,203	5,463	29,409	56	5,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,403	6,609	13,884	62	2,721	67.00
68.00	06800	SPEECH PATHOLOGY	923	2,143	1,052	0	206	68.00
69.00	06900	ELECTROCARDIOLOGY	27	9	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	355	149	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,296	2,085	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	144	340	1,201	0	235	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	109	440	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,840	51,557	92,994	268	17,538	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	307	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	407	33,262	0	0	194.02
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)	13,840	52,307	126,256	268	17,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	1,459					10.00
11.00	01100	CAFETERIA	0	68,917				11.00
13.00	01300	NURSING ADMINISTRATION	0	7,033	12,859			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	292	0	13,606		14.00
15.00	01500	PHARMACY	0	779	414	0	7,444	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,759	0	230	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,459	33,977	12,189	9,654	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	1,115	201	20	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	162	53	136	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,494	0	514	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,923	0	649	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,333	0	35	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11	2	1	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,810	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,444	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	476	0	29	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,459	68,354	12,859	13,078	7,444	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	11	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	563	0	517	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
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)	1,459	68,917	12,859	13,606	7,444	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,094					16.00
17.00	01700	SOCIAL SERVICE	0	4,179				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,778	4,179	200,503	0	200,503	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	100	0	6,564	0	6,564	54.00
60.00	06000	LABORATORY	419	0	2,837	0	2,837	60.00
65.00	06500	RESPIRATORY THERAPY	16	0	1,940	0	1,940	65.00
66.00	06600	PHYSICAL THERAPY	1,766	0	164,039	0	164,039	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,926	0	90,531	0	90,531	67.00
68.00	06800	SPEECH PATHOLOGY	740	0	12,497	0	12,497	68.00
69.00	06900	ELECTROCARDIOLOGY	22	0	72	0	72	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	284	0	2,598	0	2,598	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,840	0	13,665	0	13,665	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	115	0	7,053	0	7,053	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	88	0	637	0	637	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,094	4,179	502,936	0	502,936	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	47	0	47	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	1,402	0	1,402	194.01
194.02	07952	TENANT LEASED SPACE	0	0	100,802	0	100,802	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,094	4,179	605,187	0	605,187	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	728,820					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		591,864				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,940	2,940	5,423,232			4.00
5.01	00570	ADMITTING	15,144	15,144	148,336	32,695,049		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	57,360	57,360	328,874	0	-1,177,085	5.02
7.00	00700	OPERATION OF PLANT	133,512	133,512	187,555	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	14,424	14,424	92,009	0	0	9.00
10.00	01000	DIETARY	0	0	126,778	0	0	10.00
11.00	01100	CAFETERIA	55,728	55,728	182,141	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,560	1,560	474,717	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	11,016	11,016	8,151	0	0	14.00
15.00	01500	PHARMACY	4,668	4,668	65,321	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,352	5,352	161,270	0	0	16.00
17.00	01700	SOCIAL SERVICE	3,468	3,468	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	92,796	92,796	1,921,778	11,117,722	0	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,160	5,160	28	293,625	0	54.00
60.00	06000	LABORATORY	0	0	31,675	1,234,883	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,200	1,200	8,280	46,926	0	65.00
66.00	06600	PHYSICAL THERAPY	121,092	121,092	581,488	5,208,646	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	57,168	57,168	777,235	5,680,738	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,332	4,332	257,866	2,183,156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	321	63,662	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	838,441	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,428,724	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,944	4,944	38,483	340,161	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	258,365	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	591,864	591,864	5,392,306	32,695,049	-1,177,085	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	154	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	0	30,772	0	0	194.01
194.02	07952	TENANT LEASED SPACE	136,956	0	0	0	0	194.02
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)	357,243	247,944	963,547	263,942		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.490166	0.418921	0.177670	0.008073		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,673	13,840		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000493	0.000423		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/22/2017 1:17 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)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	8,630,362					5.02
7.00	00700	OPERATION OF PLANT	790,829	519,864				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,264	0	70,157			8.00
9.00	00900	HOUSEKEEPING	144,765	14,424	0	368,484		9.00
10.00	01000	DIETARY	230,388	0	0	0	39,948	10.00
11.00	01100	CAFETERIA	326,548	55,728	0	55,728	0	11.00
13.00	01300	NURSING ADMINISTRATION	613,734	1,560	0	1,560	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	15,814	11,016	0	11,016	0	14.00
15.00	01500	PHARMACY	102,104	4,668	0	4,668	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	264,795	5,352	0	5,352	0	16.00
17.00	01700	SOCIAL SERVICE	3,153	3,468	0	3,468	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,993,590	92,796	39,353	92,796	39,948	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,690	5,160	0	5,160	0	54.00
60.00	06000	LABORATORY	89,713	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	18,088	1,200	0	1,200	0	65.00
66.00	06600	PHYSICAL THERAPY	901,409	121,092	14,609	121,092	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,090,360	57,168	16,195	57,168	0	67.00
68.00	06800	SPEECH PATHOLOGY	353,586	4,332	0	4,332	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,406	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,596	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	344,083	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	56,097	4,944	0	4,944	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	72,553	0	0	0	0	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,506,565	382,908	70,157	368,484	39,948	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,998	0	0	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	50,666	0	0	0	0	194.01
194.02	07952	TENANT LEASED SPACE	67,133	136,956	0	0	0	194.02
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)	1,177,085	898,689	50,301	189,444	261,810	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.136389	1.728700	0.716978	0.514117	6.553770	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,307	126,256	268	17,538	1,459	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006061	0.242864	0.003820	0.047595	0.036522	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES-NURS AREAS)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	6,369					11.00
13.00	01300	NURSING ADMINISTRATION	650	2,027,403				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	27	0	134,013			14.00
15.00	01500	PHARMACY	72	65,321	0	300,257		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	255	0	2,264	0	32,695,049	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,140	1,921,778	95,084	0	11,117,722	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28	0	0	293,625	54.00
60.00	06000	LABORATORY	103	31,675	196	0	1,234,883	60.00
65.00	06500	RESPIRATORY THERAPY	15	8,280	1,343	0	46,926	65.00
66.00	06600	PHYSICAL THERAPY	785	0	5,066	0	5,208,646	66.00
67.00	06700	OCCUPATIONAL THERAPY	917	0	6,389	0	5,680,738	67.00
68.00	06800	SPEECH PATHOLOGY	308	0	341	0	2,183,156	68.00
69.00	06900	ELECTROCARDIOLOGY	1	321	11	0	63,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	17,827	0	838,441	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	300,257	5,428,724	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	44	0	285	0	340,161	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	258,365	76.01
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,317	2,027,403	128,806	300,257	32,695,049	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	111	0	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	0	0	0	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	52	0	5,096	0	0	194.01
194.02	07952	TENANT LEASED SPACE	0	0	0	0	0	194.02
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)	496,074	751,568	44,781	156,323	333,533	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	77.888837	0.370705	0.334154	0.520631	0.010201	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	68,917	12,859	13,606	7,444	11,094	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.820694	0.006343	0.101527	0.024792	0.000339	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/22/2017 1:17 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS %)	
			17.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00570	ADMITTING		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL		5.02
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 SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	6,813	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	6,813	30.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	76.01
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,813	118.00
		NONREIMBURSABLE COST CENTERS		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	NON-REIMBURSABLE COST	0	194.00
194.01	07951	MARKETING/PUBLIC RELATIONS	0	194.01
194.02	07952	TENANT LEASED SPACE	0	194.02
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)	11,361	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.667547	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,179	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.613386	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 1:17 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	5,013,573		5,013,573	0	5,013,573	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,635		42,635	0	42,635	54.00
60.00	06000	LABORATORY	134,376		134,376	0	134,376	60.00
65.00	06500	RESPIRATORY THERAPY	28,411	0	28,411	0	28,411	65.00
66.00	06600	PHYSICAL THERAPY	1,422,380	0	1,422,380	0	1,422,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,510,409	0	1,510,409	0	1,510,409	67.00
68.00	06800	SPEECH PATHOLOGY	457,901	0	457,901	0	457,901	68.00
69.00	06900	ELECTROCARDIOLOGY	2,448		2,448	0	2,448	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,461		42,461	0	42,461	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	602,713		602,713	0	602,713	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81,829		81,829	0	81,829	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	85,084		85,084	0	85,084	76.01
200.00		Subtotal (see instructions)	9,424,220	0	9,424,220	0	9,424,220	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	9,424,220	0	9,424,220	0	9,424,220	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 1:17 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	11,117,722		11,117,722			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,625	0	293,625	0.145202	0.000000	54.00
60.00	06000	LABORATORY	1,234,883	0	1,234,883	0.108817	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	46,926	0	46,926	0.605443	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,208,646	0	5,208,646	0.273081	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,668,008	12,730	5,680,738	0.265883	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,183,156	0	2,183,156	0.209743	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	63,662	0	63,662	0.038453	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	838,441	0	838,441	0.050643	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,428,724	0	5,428,724	0.111023	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	340,161	0	340,161	0.240560	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	258,365	0	258,365	0.329317	0.000000	76.01
200.00		Subtotal (see instructions)	32,682,319	12,730	32,695,049			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,682,319	12,730	32,695,049			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 1:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145202		54.00
60.00	06000	LABORATORY	0.108817		60.00
65.00	06500	RESPIRATORY THERAPY	0.605443		65.00
66.00	06600	PHYSICAL THERAPY	0.273081		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265883		67.00
68.00	06800	SPEECH PATHOLOGY	0.209743		68.00
69.00	06900	ELECTROCARDIOLOGY	0.038453		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.050643		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.111023		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.240560		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.329317		76.01
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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	5,013,573		5,013,573	0	5,013,573	30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,635		42,635	0	42,635	54.00
60.00	06000	LABORATORY	134,376		134,376	0	134,376	60.00
65.00	06500	RESPIRATORY THERAPY	28,411	0	28,411	0	28,411	65.00
66.00	06600	PHYSICAL THERAPY	1,422,380	0	1,422,380	0	1,422,380	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,510,409	0	1,510,409	0	1,510,409	67.00
68.00	06800	SPEECH PATHOLOGY	457,901	0	457,901	0	457,901	68.00
69.00	06900	ELECTROCARDIOLOGY	2,448		2,448	0	2,448	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,461		42,461	0	42,461	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	602,713		602,713	0	602,713	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81,829		81,829	0	81,829	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	85,084		85,084	0	85,084	76.01
200.00		Subtotal (see instructions)	9,424,220	0	9,424,220	0	9,424,220	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	9,424,220	0	9,424,220	0	9,424,220	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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	11,117,722		11,117,722			30.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	293,625	0	293,625	0.145202	0.000000	54.00
60.00	06000	LABORATORY	1,234,883	0	1,234,883	0.108817	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	46,926	0	46,926	0.605443	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,208,646	0	5,208,646	0.273081	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,668,008	12,730	5,680,738	0.265883	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,183,156	0	2,183,156	0.209743	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	63,662	0	63,662	0.038453	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	838,441	0	838,441	0.050643	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,428,724	0	5,428,724	0.111023	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	340,161	0	340,161	0.240560	0.000000	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	258,365	0	258,365	0.329317	0.000000	76.01
200.00		Subtotal (see instructions)	32,682,319	12,730	32,695,049			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	32,682,319	12,730	32,695,049			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145202		54.00
60.00	06000	LABORATORY	0.108817		60.00
65.00	06500	RESPIRATORY THERAPY	0.605443		65.00
66.00	06600	PHYSICAL THERAPY	0.273081		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265883		67.00
68.00	06800	SPEECH PATHOLOGY	0.209743		68.00
69.00	06900	ELECTROCARDIOLOGY	0.038453		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.050643		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.111023		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.240560		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.329317		76.01
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part II Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,635	6,564	36,071	0	0	54.00
60.00	06000	LABORATORY	134,376	2,837	131,539	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	28,411	1,940	26,471	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,422,380	164,039	1,258,341	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,510,409	90,531	1,419,878	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	457,901	12,497	445,404	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,448	72	2,376	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,461	2,598	39,863	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	602,713	13,665	589,048	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81,829	7,053	74,776	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	85,084	637	84,447	0	0	76.01
200.00		Subtotal (sum of lines 50 thru 199)	4,410,647	302,433	4,108,214	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	4,410,647	302,433	4,108,214	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part II | Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,635	293,625	0.145202		54.00
60.00	06000	LABORATORY	134,376	1,234,883	0.108817		60.00
65.00	06500	RESPIRATORY THERAPY	28,411	46,926	0.605443		65.00
66.00	06600	PHYSICAL THERAPY	1,422,380	5,208,646	0.273081		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,510,409	5,680,738	0.265883		67.00
68.00	06800	SPEECH PATHOLOGY	457,901	2,183,156	0.209743		68.00
69.00	06900	ELECTROCARDIOLOGY	2,448	63,662	0.038453		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,461	838,441	0.050643		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	602,713	5,428,724	0.111023		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	81,829	340,161	0.240560		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	85,084	258,365	0.329317		76.01
200.00		Subtotal (sum of lines 50 thru 199)	4,410,647	21,577,327			200.00
201.00		Less Observation Beds	0	0			201.00
202.00		Total (line 200 minus line 201)	4,410,647	21,577,327			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/22/2017 1:17 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	200,503	0	200,503	6,813	29.43	30.00
200.00	Total (lines 30-199)	200,503		200,503	6,813		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	2,931	86,259	30.00
200.00	Total (lines 30-199)	2,931	86,259	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/22/2017 1:17 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,564	293,625	0.022355	247,165	5,525	54.00
60.00	06000	LABORATORY	2,837	1,234,883	0.002297	543,016	1,247	60.00
65.00	06500	RESPIRATORY THERAPY	1,940	46,926	0.041342	12,816	530	65.00
66.00	06600	PHYSICAL THERAPY	164,039	5,208,646	0.031494	2,219,043	69,887	66.00
67.00	06700	OCCUPATIONAL THERAPY	90,531	5,680,738	0.015936	2,408,951	38,389	67.00
68.00	06800	SPEECH PATHOLOGY	12,497	2,183,156	0.005724	920,581	5,269	68.00
69.00	06900	ELECTROCARDIOLOGY	72	63,662	0.001131	10,954	12	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,598	838,441	0.003099	326,609	1,012	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,665	5,428,724	0.002517	1,820,747	4,583	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,053	340,161	0.020734	120,084	2,490	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	637	258,365	0.002466	182,654	450	76.01
200.00		Total (lines 50-199)	302,433	21,577,327		8,812,620	129,394	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/22/2017 1:17 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
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	6,813	0.00	2,931	0		30.00
200.00		Total (lines 30-199)	6,813		2,931	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 1:17 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 1:17 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	293,625	0.000000	0.000000	247,165	54.00
60.00	06000	LABORATORY	0	1,234,883	0.000000	0.000000	543,016	60.00
65.00	06500	RESPIRATORY THERAPY	0	46,926	0.000000	0.000000	12,816	65.00
66.00	06600	PHYSICAL THERAPY	0	5,208,646	0.000000	0.000000	2,219,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,680,738	0.000000	0.000000	2,408,951	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,183,156	0.000000	0.000000	920,581	68.00
69.00	06900	ELECTROCARDIOLOGY	0	63,662	0.000000	0.000000	10,954	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	838,441	0.000000	0.000000	326,609	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,428,724	0.000000	0.000000	1,820,747	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	340,161	0.000000	0.000000	120,084	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	258,365	0.000000	0.000000	182,654	76.01
200.00		Total (lines 50-199)	0	21,577,327			8,812,620	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 1:17 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					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0		76.01
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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	200,503	0	200,503	6,813	29.43	30.00
200.00	Total (lines 30-199)	200,503		200,503	6,813		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	893	26,281	30.00
200.00	Total (lines 30-199)	893	26,281	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,564	293,625	0.022355	21,919	490	54.00
60.00	06000	LABORATORY	2,837	1,234,883	0.002297	40,180	92	60.00
65.00	06500	RESPIRATORY THERAPY	1,940	46,926	0.041342	4,361	180	65.00
66.00	06600	PHYSICAL THERAPY	164,039	5,208,646	0.031494	167,270	5,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	90,531	5,680,738	0.015936	175,554	2,798	67.00
68.00	06800	SPEECH PATHOLOGY	12,497	2,183,156	0.005724	56,145	321	68.00
69.00	06900	ELECTROCARDIOLOGY	72	63,662	0.001131	2,795	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,598	838,441	0.003099	64,016	198	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,665	5,428,724	0.002517	199,281	502	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	7,053	340,161	0.020734	21,055	437	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	637	258,365	0.002466	0	0	76.01
200.00		Total (lines 50-199)	302,433	21,577,327		752,576	10,289	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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
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	6,813	0.00	893	0		30.00
200.00		Total (lines 30-199)	6,813		893	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0	0	0	76.01
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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	293,625	0.000000	0.000000	21,919	54.00
60.00	06000	LABORATORY	0	1,234,883	0.000000	0.000000	40,180	60.00
65.00	06500	RESPIRATORY THERAPY	0	46,926	0.000000	0.000000	4,361	65.00
66.00	06600	PHYSICAL THERAPY	0	5,208,646	0.000000	0.000000	167,270	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,680,738	0.000000	0.000000	175,554	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,183,156	0.000000	0.000000	56,145	68.00
69.00	06900	ELECTROCARDIOLOGY	0	63,662	0.000000	0.000000	2,795	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	838,441	0.000000	0.000000	64,016	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,428,724	0.000000	0.000000	199,281	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	340,161	0.000000	0.000000	21,055	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	258,365	0.000000	0.000000	0	76.01
200.00		Total (lines 50-199)	0	21,577,327			752,576	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0	0	0		76.01
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 1:17 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)	6,813	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,813	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,813	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,931	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)	5,013,573	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)	5,013,573	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,013,573	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)	735.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,156,864	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,156,864	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 1:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	1,850,443	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,007,307	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)	86,259	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	129,394	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	215,653	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	3,791,654	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 1:17 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	200,503	5,013,573	0.039992	0	0	90.00
91.00	Nursing School cost	0	5,013,573	0.000000	0	0	91.00
92.00	Allied health cost	0	5,013,573	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,013,573	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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)	6,813	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,813	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6,813	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)	893	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)	5,013,573	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)	5,013,573	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,013,573	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)	735.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	657,141	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)	657,141	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	144,865	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	802,006	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)	26,281	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,289	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	36,570	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	765,436	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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	200,503	5,013,573	0.039992	0	0	90.00
91.00	Nursing School cost	0	5,013,573	0.000000	0	0	91.00
92.00	Allied health cost	0	5,013,573	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,013,573	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/22/2017 1:17 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		4,783,644		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145202	247,165	35,889	54.00
60.00	06000	LABORATORY	0.108817	543,016	59,089	60.00
65.00	06500	RESPIRATORY THERAPY	0.605443	12,816	7,759	65.00
66.00	06600	PHYSICAL THERAPY	0.273081	2,219,043	605,978	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265883	2,408,951	640,499	67.00
68.00	06800	SPEECH PATHOLOGY	0.209743	920,581	193,085	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038453	10,954	421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.050643	326,609	16,540	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.111023	1,820,747	202,145	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.240560	120,084	28,887	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.329317	182,654	60,151	76.01
200.00		Total (sum of lines 50-94 and 96-98)		8,812,620	1,850,443	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)		8,812,620		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/22/2017 1:17 pm

Title XIX | 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		350,410		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.145202	21,919	3,183	54.00
60.00	06000	LABORATORY	0.108817	40,180	4,372	60.00
65.00	06500	RESPIRATORY THERAPY	0.605443	4,361	2,640	65.00
66.00	06600	PHYSICAL THERAPY	0.273081	167,270	45,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.265883	175,554	46,677	67.00
68.00	06800	SPEECH PATHOLOGY	0.209743	56,145	11,776	68.00
69.00	06900	ELECTROCARDIOLOGY	0.038453	2,795	107	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.050643	64,016	3,242	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.111023	199,281	22,125	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.240560	21,055	5,065	76.00
76.01	03950	HEMODIALYSIS & OTHER ANCILLARY	0.329317	0	0	76.01
200.00		Total (sum of lines 50-94 and 96-98)		752,576	144,865	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)		752,576		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 2/22/2017 1:17 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		4,799,526		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)		4,799,526		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		9,466		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,808,992		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	Provider CCN: 15-3030	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part III Date/Time Prepared: 2/22/2017 1:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,678,408	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0221	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	216,610	3.00
4.00	Outlier Payments	72,478	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	18.614754	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,967,496	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,967,496	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,967,496	19.00
20.00	Deductibles	29,568	20.00
21.00	Subtotal (line 19 minus line 20)	4,937,928	21.00
22.00	Coinsurance	30,793	22.00
23.00	Subtotal (line 21 minus line 22)	4,907,135	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,907,135	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,907,135	32.00
32.01	Sequestration adjustment (see instructions)	98,143	32.01
33.00	Interim payments	4,799,526	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	9,466	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	4,211	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	72,478	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-3030	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 2/22/2017 1:17 pm
	Title XIX	Hospital	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	752,576	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	752,576	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	752,576	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	752,576	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/22/2017 1:17 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	-4,690	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	2,008,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-188,042	0	0	0	6.00
7.00	Inventory	31,802	0	0	0	7.00
8.00	Prepaid expenses	43,622	0	0	0	8.00
9.00	Other current assets	348	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)	1,891,040	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	900,000	0	0	0	12.00
13.00	Land improvements	276,453	0	0	0	13.00
14.00	Accumulated depreciation	-122,218	0	0	0	14.00
15.00	Buildings	11,624,398	0	0	0	15.00
16.00	Accumulated depreciation	-2,281,757	0	0	0	16.00
17.00	Leasehold improvements	235,036	0	0	0	17.00
18.00	Accumulated depreciation	-78,891	0	0	0	18.00
19.00	Fixed equipment	137,063	0	0	0	19.00
20.00	Accumulated depreciation	-55,237	0	0	0	20.00
21.00	Automobiles and trucks	113,428	0	0	0	21.00
22.00	Accumulated depreciation	-95,221	0	0	0	22.00
23.00	Major movable equipment	203,107	0	0	0	23.00
24.00	Accumulated depreciation	-139,964	0	0	0	24.00
25.00	Minor equipment depreciable	299,449	0	0	0	25.00
26.00	Accumulated depreciation	-231,385	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)	10,784,261	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	591,065	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	591,065	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,266,366	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	260,011	0	0	0	37.00
38.00	Salaries, wages, and fees payable	518,162	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	16,216,177	0	0	0	43.00
44.00	Other current liabilities	188,864	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,183,214	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)	17,183,214	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-3,916,848				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)	-3,916,848	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,266,366	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/22/2017 1:17 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		17,313,486		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-408,631				2.00
3.00	Total (sum of line 1 and line 2)		16,904,855		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)		16,904,855		0		11.00
12.00	ADJUSTMENTS	20,821,703		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)		20,821,703		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-3,916,848		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	ADJUSTMENTS		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: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/22/2017 1:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,117,722		11,117,722	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				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)	11,117,722		11,117,722	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,117,722		11,117,722	17.00
18.00	Ancillary services	21,564,597	12,730	21,577,327	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				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)	32,682,319	12,730	32,695,049	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		10,017,255		29.00
30.00	ROUNDING	3			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)		3		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)		10,017,258		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-3030 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-3 | Date/Time Prepared: 2/22/2017 1:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	32,695,049	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,177,953	2.00
3.00	Net patient revenues (line 1 minus line 2)	9,517,096	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	10,017,258	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-500,162	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 OPERATING REVENUE	91,531	24.00
25.00	Total other income (sum of lines 6-24)	91,531	25.00
26.00	Total (line 5 plus line 25)	-408,631	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-408,631	29.00