

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S Parts I-III Date/Time Prepared: 8/29/2016 11:29 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 8/29/2016 Time: 11:29 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HERRIN HOSPITAL ( 140011 ) for the cost reporting period beginning 04/01/2015 and ending 03/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-1,063,109	-103,726	-18,560	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	11,935	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	-1,051,174	-103,726	-18,560	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: 140011		Period: From 04/01/2015 To 03/31/2016		Worksheet S-2 Part I Date/Time Prepared: 8/29/2016 11:28 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 201 S. 14TH STREET			PO Box:						1.00	
2.00	City: HERRIN			State: IL		Zip Code: 62948		County: WILLIAMSON		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		HERRIN HOSPITAL	140011	16060	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		HERRIN HOSPITAL ACUTE REHAB	14T011	16060	5	04/01/1998	N	P	0	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2015	03/31/2016		20.00	
21.00	Type of Control (see instructions)						2			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) (Pickles amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	Y		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.							1	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 IPFS 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.			3,056	73	0	0	75	153		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.			721	102	0	0	123			25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part I Date/Time Prepared: 8/29/2016 11:28 am			
		Urban/Rural S	Date of Geogr				
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			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.	2	09/15/2014		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.	1			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.	04/01/2015	03/31/2016		38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00		
		V	XVII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
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		
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
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
<b>Inpatient Rehabilitation Facility PPS</b>						
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
				1.00	2.00	3.00
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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			V	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
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a critical access hospital (CAH)?		N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108.00
		Physical	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.					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
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,584,229	0	0		
				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	Y		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N			122.00
<b>Transplant Center Information</b>						
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: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part I Date/Time Prepared: 8/29/2016 11:28 am			
		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	14H124	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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 1239 E MAIN STREET	PO Box: 3988				142.00	
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00			
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	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		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0		168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.50		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part I Date/Time Prepared: 8/29/2016 11:28 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2015	09/28/2015	170.00
			1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part II Date/Time Prepared: 8/29/2016 11:28 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		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.	Y			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	06/07/2016	Y	06/07/2016
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet S-2  
Part II  
Date/Time Prepared:  
8/29/2016 11:28 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N	N	21.00
					1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>						
<b>Capital Related Cost</b>						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N		27.00
<b>Interest Expense</b>						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N		31.00
<b>Purchased Services</b>						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N		33.00
<b>Provider-Based Physicians</b>						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y		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.			Y		35.00
				Y/N	Date	
				1.00	2.00	
<b>Home Office Costs</b>						
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		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	
<b>Cost Report Preparer Contact Information</b>						
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.	LUANNE		WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SIH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6184575200		LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part II Date/Time Prepared: 8/29/2016 11:28 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part IX Date/Time Prepared: 8/29/2016 11:28 am
		Title V	Title XIX	
		1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
<b>RHC</b>				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,182	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)		77	28,182	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		85	31,110	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	29	10,614		0	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						26.25
27.00 Total (sum of lines 14-26)		114				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: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	11,236	2,705	18,350			1.00
2.00 HMO and other (see instructions)	1,501	228				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	282	123				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)	11,236	2,705	18,350			7.00
8.00 INTENSIVE CARE UNIT	1,103	424	2,080			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)	12,339	3,129	20,430	0.00	714.14	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	4,754	823	7,148	0.00	55.58	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						26.25
27.00 Total (sum of lines 14-26)				0.00	769.72	27.00
28.00 Observation Bed Days		539	2,221			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: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,289	1,011	6,061	1.00
2.00 HMO and other (see instructions)			392	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	3,289	1,011	6,061	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	335	58	517	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						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140011		Period: From 04/01/2015 To 03/31/2016		Worksheet S-3 Part II Date/Time Prepared: 8/29/2016 11:28 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	41,948,393	0	41,948,393	1,662,592.94	25.23	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		140,325	0	140,325	2,048.00	68.52	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,111,103	-152,525	2,958,578	120,048.02	24.64	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		66,714	0	66,714	1,038.00	64.27	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		188,171	0	188,171	1,511.00	124.53	13.00
14.00	Home office salaries & wage-related costs		8,961,558	0	8,961,558	206,433.05	43.41	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		9,698,210	0	9,698,210			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		738,566	0	738,566			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		35,030	0	35,030			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	283,182	0	283,182	10,485.01	27.01	26.00
27.00	Administrative & General	5.00	4,385,803	0	4,385,803	136,329.25	32.17	27.00
28.00	Administrative & General under contract (see inst.)		443,929	0	443,929	1,346.31	329.74	28.00
29.00	Maintenance & Repairs	6.00	569,338	0	569,338	25,236.39	22.56	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	39,799	0	39,799	2,965.21	13.42	31.00
32.00	Housekeeping	9.00	924,324	0	924,324	77,842.40	11.87	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,006,790	-648,291	358,499	24,630.10	14.56	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	648,291	648,291	44,536.15	14.56	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	990,967	0	990,967	28,938.08	34.24	38.00
39.00	Central Services and Supply	14.00	146,349	0	146,349	9,989.10	14.65	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet S-3  
Part II  
Date/Time Prepared:  
8/29/2016 11:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 351,274	0	351,274	23,667.21	14.84	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet S-3  
Part III  
Date/Time Prepared:  
8/29/2016 11:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	42,251,997	0	42,251,997	1,661,891.25	25.42	1.00
2.00	Excluded area salaries (see instructions)	3,111,103	-152,525	2,958,578	120,048.02	24.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)	39,140,894	152,525	39,293,419	1,541,843.23	25.48	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,216,443	0	9,216,443	208,982.05	44.10	4.00
5.00	Subtotal wage-related costs (see inst.)	9,698,210	0	9,698,210	0.00	24.68	5.00
6.00	Total (sum of lines 3 thru 5)	58,055,547	152,525	58,208,072	1,750,825.28	33.25	6.00
7.00	Total overhead cost (see instructions)	9,141,755	0	9,141,755	385,965.21	23.69	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 8/29/2016 11:28 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			726,866 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			2,238 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			5,185,196 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			76,014 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			32,741 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			107,948 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			614,228 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			457,881 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			3,026,288 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			11,609 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			105,976 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			124,821 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			10,471,806 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet S-3  
Part V  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	66,714	10,471,806	1.00
2.00	Hospital	66,714	10,471,806	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet S-10
				Date/Time Prepared: 8/29/2016 11:28 am
				1.00
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.210114	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		10,853,639	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,249,833	5.00
6.00	Medicaid charges		120,285,053	6.00
7.00	Medicaid cost (line 1 times line 6)		25,273,574	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		12,170,102	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		6,696	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		12,170,102	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,383,699	1,557,219	4,940,918
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	710,963	327,194	1,038,157
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	710,963	327,194	1,038,157
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		9,229,896	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		946,718	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		8,283,178	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,740,412	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,778,569	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		14,948,671	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet A  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		3,601,071	3,601,071	27,605	3,628,676	1.00
2.00	00200		2,584,225	2,584,225	12,200	2,596,425	2.00
4.00	00400	283,182	13,564,060	13,847,242	0	13,847,242	4.00
5.01	00550	0	0	0	0	0	5.01
5.02	00560	119,801	89,965	209,766	0	209,766	5.02
5.03	00580	768,882	80,074	848,956	0	848,956	5.03
5.04	00590	3,497,120	7,226,417	10,723,537	-22,358	10,701,179	5.04
6.00	00600	569,338	1,168,759	1,738,097	0	1,738,097	6.00
8.00	00800	39,799	374,781	414,580	0	414,580	8.00
9.00	00900	924,324	343,939	1,268,263	0	1,268,263	9.00
10.00	01000	1,006,790	739,824	1,746,614	-1,124,677	621,937	10.00
11.00	01100	0	0	0	1,124,677	1,124,677	11.00
13.00	01300	990,967	51,705	1,042,672	0	1,042,672	13.00
14.00	01400	146,349	68,111	214,460	-1,040	213,420	14.00
16.00	01600	351,274	24,366	375,640	0	375,640	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	1,045,038	1,045,038	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	7,347,004	4,501,442	11,848,446	-15,995	11,832,451	30.00
31.00	03100	1,567,421	359,515	1,926,936	-6,932	1,920,004	31.00
41.00	04100	2,958,578	1,485,167	4,443,745	-605	4,443,140	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,951,769	9,215,714	13,167,483	-11,115,471	2,052,012	50.00
51.00	05100	657,434	49,284	706,718	0	706,718	51.00
53.00	05300	368,270	1,369,926	1,738,196	-1,111,094	627,102	53.00
54.00	05400	1,827,280	811,788	2,639,068	-134,893	2,504,175	54.00
56.00	05600	298,133	1,221,714	1,519,847	-191,256	1,328,591	56.00
57.00	05700	421,755	499,732	921,487	-57,362	864,125	57.00
58.00	05800	313,231	226,448	539,679	-49,474	490,205	58.00
60.00	06000	1,559,613	3,191,936	4,751,549	518,803	5,270,352	60.00
65.00	06500	1,122,146	267,961	1,390,107	-78,144	1,311,963	65.00
66.00	06600	4,627,391	1,735,153	6,362,544	-489	6,362,055	66.00
69.00	06900	623,073	468,411	1,091,484	-186,145	905,339	69.00
71.00	07100	0	0	0	7,136,951	7,136,951	71.00
72.00	07200	0	4,575,784	4,575,784	4,575,784	9,151,568	72.00
73.00	07300	1,946,978	4,262,810	6,209,788	236,571	6,446,359	73.00
76.97	07697	428,320	23,384	451,704	0	451,704	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	182,469	488,613	671,082	-12,317	658,765	90.00
91.00	09100	2,897,177	3,207,768	6,104,945	-10,086	6,094,859	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		2,165,984	2,165,984	-39,805	2,126,179	113.00
118.00		41,795,868	70,045,831	111,841,699	519,486	112,361,185	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	98,122	98,122	0	98,122	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	152,525	366,961	519,486	-519,486	0	192.02
200.00		41,948,393	70,510,914	112,459,307	0	112,459,307	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet A  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-87,254	3,541,422	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,575,364	5,171,789	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	368,935	14,216,177	4.00
5.01	00550	DATA PROCESSING	4,833,072	4,833,072	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-3,910	205,856	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,421,486	3,270,442	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	4,364,892	15,066,071	5.04
6.00	00600	MAINTENANCE & REPAIRS	-42	1,738,055	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	414,580	8.00
9.00	00900	HOUSEKEEPING	0	1,268,263	9.00
10.00	01000	DIETARY	0	621,937	10.00
11.00	01100	CAFETERIA	-523,641	601,036	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,042,672	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	213,420	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-72,199	303,441	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,045,038	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,421,426	9,411,025	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,920,004	31.00
41.00	04100	SUBPROVIDER - I RF	-1,354,326	3,088,814	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-21,274	2,030,738	50.00
51.00	05100	RECOVERY ROOM	0	706,718	51.00
53.00	05300	ANESTHESIOLOGY	0	627,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-71,291	2,432,884	54.00
56.00	05600	RADIOISOTOPE	0	1,328,591	56.00
57.00	05700	CT SCAN	0	864,125	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	490,205	58.00
60.00	06000	LABORATORY	-61,303	5,209,049	60.00
65.00	06500	RESPIRATORY THERAPY	-15,542	1,296,421	65.00
66.00	06600	PHYSICAL THERAPY	-210,348	6,151,707	66.00
69.00	06900	ELECTROCARDIOLOGY	-151,708	753,631	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,136,951	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,151,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,446,359	73.00
76.97	07697	CARDIAC REHABILITATION	-1,740	449,964	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-6,994	651,771	90.00
91.00	09100	EMERGENCY	-2,185,858	3,909,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	-2,126,179	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,203,676	116,564,861	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-16,667	81,455	192.00
192.01	19201	VACANT SPACE	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	192.02
200.00		TOTAL (SUM OF LINES 118-199)	4,187,009	116,646,316	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140011

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Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01 DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02 PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00 MAINTENANCE & REPAIRS	00600		6.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
19.00 NONPHYSICIAN ANESTHETISTS	01900		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
41.00 SUBPROVIDER - IRF	04100		41.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
69.00 ELECTROCARDIOLOGY	06900		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
76.97 CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01 VACANT SPACE	19201		192.01
192.02 REFERENCE LAB	19202		192.02
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140011

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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - DIETARY RECLASS</b>					
1.00	CAFETERIA	11.00	648,291	476,386	1.00
	TOTALS		648,291	476,386	
<b>B - MEDICAL SUPPLY RECLASS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,712,735	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	11,712,735	
<b>C - CRNA RECLASS</b>					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,045,038	1.00
	TOTALS		0	1,045,038	
<b>D - INTEREST RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27,605	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,200	2.00
	TOTALS		0	39,805	
<b>E - BARIATRIC PROGRAM MED DIR RECLASS</b>					
1.00	OPERATING ROOM	50.00	0	10,800	1.00
	TOTALS		0	10,800	
<b>F - IMPLANTABLE DEVICE RECLASS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,575,784	1.00
	TOTALS		0	4,575,784	
<b>G - CONTRAST DRUG RECLASS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	237,220	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	237,220	
<b>H - REFERENCE LAB RECLASS</b>					
1.00	LABORATORY	60.00	152,525	366,961	1.00
	TOTALS		152,525	366,961	
<b>I - EEG MEDICAL DIRECTOR RECLASS</b>					
1.00	RESPIRATORY THERAPY	65.00	0	3,338	1.00
	TOTALS		0	3,338	
<b>J - RESPIRATORY CARE MED DIR RECLASS</b>					
1.00	RESPIRATORY THERAPY	65.00	0	1,560	1.00
	TOTALS		0	1,560	
<b>K - UROLOGY MED DIR RECLASS</b>					
1.00	OPERATING ROOM	50.00	0	3,880	1.00
	TOTALS		0	3,880	
<b>L - ENDOSCOPY MED DIR RECLASS</b>					
1.00	OPERATING ROOM	50.00	0	3,120	1.00
	TOTALS		0	3,120	
<b>M - CARDIO MED DIR RECLASS</b>					
1.00	ELECTROCARDIOLOGY	69.00	0	275	1.00
	TOTALS		0	275	
<b>N - ER MED DIR RECLASS</b>					
1.00	EMERGENCY	91.00	0	4,244	1.00
	TOTALS		0	4,244	
500.00	Grand Total: Increases		800,816	18,481,146	500.00

RECLASSIFICATIONS

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - DIETARY RECLASS</b>							
1.00	DIETARY	10.00	648,291	476,386	0		1.00
	TOTALS		648,291	476,386			
<b>B - MEDICAL SUPPLY RECLASS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	314	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	15,995	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	605	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	5,372	0		4.00
5.00	OPERATING ROOM	50.00	0	11,133,271	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,040	0		6.00
7.00	EMERGENCY	91.00	0	10,992	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	66,056	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	100,851	0		9.00
10.00	RADIOISOTOPE	56.00	0	191,256	0		10.00
11.00	CT SCAN	57.00	0	6,902	0		11.00
12.00	LABORATORY	60.00	0	683	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	82,767	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	489	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	83,176	0		15.00
16.00	CLINIC	90.00	0	12,317	0		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	649	0		17.00
	TOTALS		0	11,712,735			
<b>C - CRNA RECLASS</b>							
1.00	ANESTHESIOLOGY	53.00	0	1,045,038	0		1.00
	TOTALS		0	1,045,038			
<b>D - INTEREST RECLASS</b>							
1.00	INTEREST EXPENSE	113.00	0	39,805	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	39,805			
<b>E - BARIATRIC PROGRAM MED DIR RECLASS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	10,800	0		1.00
	TOTALS		0	10,800			
<b>F - IMPLANTABLE DEVICE RECLASS</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,575,784	0		1.00
	TOTALS		0	4,575,784			
<b>G - CONTRAST DRUG RECLASS</b>							
1.00	ELECTROCARDIOLOGY	69.00	0	103,244	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,042	0		2.00
3.00	CT SCAN	57.00	0	50,460	0		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	49,474	0		4.00
	TOTALS		0	237,220			
<b>H - REFERENCE LAB RECLASS</b>							
1.00	REFERENCE LAB	192.02	152,525	366,961	0		1.00
	TOTALS		152,525	366,961			
<b>I - EEG MEDICAL DIRECTOR RECLASS</b>							
1.00	EMERGENCY	91.00	0	3,338	0		1.00
	TOTALS		0	3,338			
<b>J - RESPIRATORY CARE MED DIR RECLASS</b>							
1.00	INTENSIVE CARE UNIT	31.00	0	1,560	0		1.00
	TOTALS		0	1,560			
<b>K - UROLOGY MED DIR RECLASS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3,880	0		1.00
	TOTALS		0	3,880			
<b>L - ENDOSCOPY MED DIR RECLASS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3,120	0		1.00
	TOTALS		0	3,120			
<b>M - CARDIO MED DIR RECLASS</b>							
1.00	RESPIRATORY THERAPY	65.00	0	275	0		1.00
	TOTALS		0	275			
<b>N - ER MED DIR RECLASS</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	4,244	0		1.00
	TOTALS		0	4,244			
500.00	Grand Total: Decreases		800,816	18,481,146			500.00

RECLASSIFICATIONS

Provider CCN: 140011

Period: From 04/01/2015 To 03/31/2016

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Increases					Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
<b>A - DIETARY RECLASS</b>									
1.00	CAFETERIA	11.00	648,291	476,386	DIETARY	10.00	648,291	476,386	
	TOTALS		648,291	476,386	TOTALS		648,291	476,386	
<b>B - MEDICAL SUPPLY RECLASS</b>									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,712,735	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	314	
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	15,995	
3.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	605	
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	5,372	
5.00		0.00	0	0	OPERATING ROOM	50.00	0	11,133,271	
6.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	1,040	
7.00		0.00	0	0	EMERGENCY	91.00	0	10,992	
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	66,056	
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	100,851	
10.00		0.00	0	0	RADIOISOTOPE	56.00	0	191,256	
11.00		0.00	0	0	CT SCAN	57.00	0	6,902	
12.00		0.00	0	0	LABORATORY	60.00	0	683	
13.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	82,767	
14.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	489	
15.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	83,176	
16.00		0.00	0	0	CLINIC	90.00	0	12,317	
17.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	649	
	TOTALS		0	11,712,735	TOTALS		0	11,712,735	
<b>C - CRNA RECLASS</b>									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	1,045,038	ANESTHESIOLOGY	53.00	0	1,045,038	
	TOTALS		0	1,045,038	TOTALS		0	1,045,038	
<b>D - INTEREST RECLASS</b>									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27,605	INTEREST EXPENSE	113.00	0	39,805	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,200		0.00	0	0	
	TOTALS		0	39,805	TOTALS		0	39,805	
<b>E - BARIATRIC PROGRAM MED DIR RECLASS</b>									
1.00	OPERATING ROOM	50.00	0	10,800	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	10,800	
	TOTALS		0	10,800	TOTALS		0	10,800	
<b>F - IMPLANTABLE DEVICE RECLASS</b>									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,575,784	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,575,784	
	TOTALS		0	4,575,784	TOTALS		0	4,575,784	
<b>G - CONTRAST DRUG RECLASS</b>									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	237,220	ELECTROCARDIOLOGY	69.00	0	103,244	
2.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	34,042	
3.00		0.00	0	0	CT SCAN	57.00	0	50,460	
4.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	49,474	
	TOTALS		0	237,220	TOTALS		0	237,220	
<b>H - REFERENCE LAB RECLASS</b>									
1.00	LABORATORY	60.00	152,525	366,961	REFERENCE LAB	192.02	152,525	366,961	
	TOTALS		152,525	366,961	TOTALS		152,525	366,961	
<b>I - EEG MEDICAL DIRECTOR RECLASS</b>									
1.00	RESPIRATORY THERAPY	65.00	0	3,338	EMERGENCY	91.00	0	3,338	
	TOTALS		0	3,338	TOTALS		0	3,338	
<b>J - RESPIRATORY CARE MED DIR RECLASS</b>									
1.00	RESPIRATORY THERAPY	65.00	0	1,560	INTENSIVE CARE UNIT	31.00	0	1,560	
	TOTALS		0	1,560	TOTALS		0	1,560	
<b>K - UROLOGY MED DIR RECLASS</b>									
1.00	OPERATING ROOM	50.00	0	3,880	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3,880	
	TOTALS		0	3,880	TOTALS		0	3,880	
<b>L - ENDOSCOPY MED DIR RECLASS</b>									
1.00	OPERATING ROOM	50.00	0	3,120	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3,120	
	TOTALS		0	3,120	TOTALS		0	3,120	
<b>M - CARDIO MED DIR RECLASS</b>									
1.00	ELECTROCARDIOLOGY	69.00	0	275	RESPIRATORY THERAPY	65.00	0	275	
	TOTALS		0	275	TOTALS		0	275	

RECLASSIFICATIONS

Provider CCN: 140011

Period:  
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	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	N - ER MED DIR RECLASS								
1.00	EMERGENCY	91.00	0	4,244	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	4,244	1.00
	TOTALS		0	4,244	TOTALS		0	4,244	
500.00	Grand Total: Increases		800,816	18,481,146	Grand Total: Decreases		800,816	18,481,146	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet A-7  
Part I  
Date/Time Prepared:  
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	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	3,782,103	128,290	0	128,290	13,297	1.00
2.00	Land Improvements	4,328,698	138,203	0	138,203	18,630	2.00
3.00	Buildings and Fixtures	38,011,924	1,505,131	0	1,505,131	83,624	3.00
4.00	Building Improvements	29,837,675	1,120,165	0	1,120,165	30,831	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	28,586,704	4,814,269	0	4,814,269	4,233,777	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	104,547,104	7,706,058	0	7,706,058	4,380,159	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	104,547,104	7,706,058	0	7,706,058	4,380,159	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	3,897,096	0				1.00
2.00	Land Improvements	4,448,271	0				2.00
3.00	Buildings and Fixtures	39,433,431	0				3.00
4.00	Building Improvements	30,927,009	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	29,167,196	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	107,873,003	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	107,873,003	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet A-7  
Part II  
Date/Time Prepared:  
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	3,601,071	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,584,225	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,185,296	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	3,601,071				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,584,225				2.00
3.00	Total (sum of lines 1-2)	0	6,185,296				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet A-7  
Part III  
Date/Time Prepared:  
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Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	78,705,807	0	78,705,807	0.729615	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	29,167,196	0	29,167,196	0.270385	0	2.00
3.00	Total (sum of lines 1-2)	107,873,003	0	107,873,003	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,541,422	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,171,789	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,713,211	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	3,541,422	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,171,789	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	8,713,211	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet A-8

Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
1.00	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			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)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-6,228,023				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	22,103,149				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-523,641	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-72,199	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-1,045,038	NONPHYSICIAN ANESTHETISTS		19.00	0	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	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 TELEVISION AND RADIO SERVICE	A	-444	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.01 INTEREST INCOME UNRESTRICTED	B	-354,724	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.01
33.02 PAYMENTS FOR OUTPATIENT SERVICES	B	-2,932,278	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.02
33.03 NONALLOWABLE BOND EXPENSE	A	-2,126,179	INTEREST EXPENSE	113.00	0 33.03
33.04 PURCHASE DISCOUNTS	B	-3,910	PURCHASING RECEIVING AND STORES	5.02	0 33.04
33.05 CABLE TV	A	-1,034	SUBPROVIDER - IRF	41.00	0 33.05
33.06 OFFSET OF LOBBYING EXPENSES	A	-24,376	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.06
33.07 COMMUNITY DONATIONS	A	-8,972	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.07
33.08 LEASEHOLD REVENUE	B	-321,764	CAP REL COSTS-BLDG & FIXT	1.00	9 33.08
33.09 DEBT FORGIVENESS	A	-2,002,124	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.09
33.10 FUNDED DEPRECIATION	A	-1,138	CAP REL COSTS-BLDG & FIXT	1.00	9 33.10
33.11 REAL ESTATE TAXES	A	-49,294	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.11
33.12 MEDI CAID PROVIDER TAX	A	-2,444,905	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.12
33.13 MISCELLANEOUS INCOME	B	-3,022	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.13
33.14 CABLE TV	A	-933	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.14
33.15 XRAY FILM/SILVER REVENUE	B	-1,262	RADIOLOGY-DIAGNOSTIC	54.00	0 33.15
33.16 LOSS ON 1991 BONDS	A	112,722	CAP REL COSTS-BLDG & FIXT	1.00	9 33.16
33.17 LOSS ON 1991 BONDS	A	154,645	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.17
33.18 REAL ESTATE TAXES	A	-16,667	PHYSICIANS' PRIVATE OFFICES	192.00	0 33.18
33.19 MISCELLANEOUS INCOME	B	-42	MAINTENANCE & REPAIRS	6.00	0 33.19
33.20 REAL ESTATE TAXES	A	-15,889	PHYSICAL THERAPY	66.00	0 33.20
33.21 PERSONAL USE OF PROVIDER VEHICLES	A	-2,679	OTHER ADMINISTRATIVE AND GENERAL	5.04	0 33.21
33.22 DR. TIBREWALA OVERPAYMENT	A	-1,040	OPERATING ROOM	50.00	0 33.22
33.23 DR. PRAMOTE DOUBLE PAYMENT JUNE 2015	A	-275	RESPIRATORY THERAPY	65.00	0 33.23
33.24 DR. PRAMOTE DOUBLE PAYMENT JUNE 2015	A	-275	ELECTROCARDIOLOGY	69.00	0 33.24
33.25 DR. QURESHI OVERPAYMENT OCTOBER 2015	A	-1,380	EMERGENCY	91.00	0 33.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		4,187,009			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: 140011

Period: From 04/01/2015 To 03/31/2016

Worksheet A-8-1

Date/Time Prepared: 8/29/2016 11:28 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	122,926	0 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2,421,163	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	3,301,213	0 3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	4,833,072	0 4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	2,421,486	0 4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	9,255,921	0 4.02
4.03	90.00	CLINIC	RENT	9,724	16,329 4.03
4.04	60.00	LABORATORY	RENT	26,288	81,191 4.04
4.05	54.00	RADIOLOGY-DIAGNOSTIC	RENT	37,639	107,668 4.05
4.06	66.00	PHYSICAL THERAPY	RENT	64,010	185,105 4.06
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			22,493,442	390,293 5.00

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

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

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

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

6.00	B	SIHS	100.00	SIHS	100.00	6.00
7.00	B	SIHE	100.00	SIHE	100.00	7.00
8.00	B	HSSI	100.00	HSSI	100.00	8.00
9.00	B	SIMS	100.00	SIMS	100.00	9.00
10.00	B	SIH CAYMAN	100.00	SIH CAYMAN	100.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet A-8-1

Date/Time Prepared:  
8/29/2016 11:28 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	122,926	9		1.00
2.00	2,421,163	9		2.00
3.00	3,301,213	0		3.00
4.00	4,833,072	0		4.00
4.01	2,421,486	0		4.01
4.02	9,255,921	0		4.02
4.03	-6,605	0		4.03
4.04	-54,903	0		4.04
4.05	-70,029	0		4.05
4.06	-121,095	0		4.06
5.00	22,103,149			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		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: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet A-8-2

Date/Time Prepared:  
8/29/2016 11:28 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	DR. A	80,000	0	80,000	208,000	736	1.00
2.00	65.00	DR. B	37,240	0	37,240	159,800	286	2.00
3.00	69.00	DR. C	153,892	150,344	3,548	159,800	32	3.00
4.00	76.97	DR. D	5,812	0	5,812	159,800	53	4.00
5.00	91.00	DR. E	2,193,006	2,177,722	15,284	159,800	111	5.00
6.00	30.00	DR. F	2,421,426	2,421,426	0	0	0	6.00
7.00	41.00	DR. G	1,353,292	1,353,292	0	0	0	7.00
8.00	50.00	DR. H	45,207	0	45,207	182,900	284	8.00
9.00	90.00	DR. I	1,080	0	1,080	159,800	9	9.00
10.00	66.00	DR. J	73,364	73,364	0	0	0	10.00
200.00			6,364,319	6,176,148	188,171		1,511	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	60.00	DR. A	73,600	3,680	0	0	0	1.00
2.00	65.00	DR. B	21,973	1,099	0	0	0	2.00
3.00	69.00	DR. C	2,459	123	0	0	0	3.00
4.00	76.97	DR. D	4,072	204	0	0	0	4.00
5.00	91.00	DR. E	8,528	426	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	41.00	DR. G	0	0	0	0	0	7.00
8.00	50.00	DR. H	24,973	1,249	0	0	0	8.00
9.00	90.00	DR. I	691	35	0	0	0	9.00
10.00	66.00	DR. J	0	0	0	0	0	10.00
200.00			136,296	6,816	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	60.00	DR. A	0	73,600	6,400	6,400	1.00
2.00	65.00	DR. B	0	21,973	15,267	15,267	2.00
3.00	69.00	DR. C	0	2,459	1,089	151,433	3.00
4.00	76.97	DR. D	0	4,072	1,740	1,740	4.00
5.00	91.00	DR. E	0	8,528	6,756	2,184,478	5.00
6.00	30.00	DR. F	0	0	0	2,421,426	6.00
7.00	41.00	DR. G	0	0	0	1,353,292	7.00
8.00	50.00	DR. H	0	24,973	20,234	20,234	8.00
9.00	90.00	DR. I	0	691	389	389	9.00
10.00	66.00	DR. J	0	0	0	73,364	10.00
200.00			0	136,296	51,875	6,228,023	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period: From 04/01/2015 To 03/31/2016

Worksheet B Part I Date/Time Prepared: 8/29/2016 11:28 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,541,422	3,541,422			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,171,789		5,171,789		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	14,216,177	25,303	5,037	14,246,517	4.00
5.01 00550	DATA PROCESSING	4,833,072	16,522	0	0	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	205,856	30,205	2,504	40,963	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	3,270,442	24,388	7,601	262,902	5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	15,066,071	660,197	113,613	1,195,763	5.04
6.00 00600	MAINTENANCE & REPAIRS	1,738,055	376,337	15,848	194,673	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	414,580	0	632	13,608	8.00
9.00 00900	HOUSEKEEPING	1,268,263	52,844	20,249	316,052	9.00
10.00 01000	DIETARY	621,937	52,103	40,420	122,581	10.00
11.00 01100	CAFETERIA	601,036	67,253	0	221,669	11.00
13.00 01300	NURSING ADMINISTRATION	1,042,672	25,192	294,082	338,839	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	213,420	34,840	7,609	50,041	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	303,441	0	17,717	120,110	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	9,411,025	519,340	310,644	2,512,163	30.00
31.00 03100	INTENSIVE CARE UNIT	1,920,004	67,489	95,674	535,945	31.00
41.00 04100	SUBPROVIDER - I/R	3,088,814	288,386	97,637	1,011,621	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,030,738	245,868	1,625,880	1,351,220	50.00
51.00 05100	RECOVERY ROOM	706,718	17,956	9,126	224,795	51.00
53.00 05300	ANESTHESIOLOGY	627,102	0	73,025	125,922	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,432,884	150,349	799,612	624,798	54.00
56.00 05600	RADIOISOTOPE	1,328,591	25,003	176,856	101,940	56.00
57.00 05700	CT SCAN	864,125	16,080	231,954	144,210	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	490,205	12,202	183,642	107,102	58.00
60.00 06000	LABORATORY	5,209,049	107,674	365,288	585,428	60.00
65.00 06500	RESPIRATORY THERAPY	1,296,421	49,139	107,782	383,693	65.00
66.00 06600	PHYSICAL THERAPY	6,151,707	201,490	95,592	1,582,235	66.00
69.00 06900	ELECTROCARDIOLOGY	753,631	20,274	175,875	213,046	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,136,951	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,151,568	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,446,359	32,018	54,895	665,726	73.00
76.97 07697	CARDIAC REHABILITATION	449,964	31,908	18,618	146,455	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	651,771	0	0	62,391	90.00
91.00 09100	EMERGENCY	3,909,001	153,975	220,939	990,626	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	116,564,861	3,304,335	5,168,351	14,246,517	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,884	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	81,455	0	3,438	0	192.00
192.01 19201	VACANT SPACE	0	220,203	0	0	192.01
192.02 19202	REFERENCE LAB	0	0	0	0	192.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	116,646,316	3,541,422	5,171,789	14,246,517	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	313,441					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,653	3,756,900				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	9	0	17,300,176	17,300,176		5.04
6.00	00600	MAINTENANCE & REPAIRS	6	0	2,453,789	427,303	2,881,092	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	428,820	74,675	0	8.00
9.00	00900	HOUSEKEEPING	152	0	1,671,125	291,010	63,213	9.00
10.00	01000	DIETARY	12	0	891,314	155,213	62,327	10.00
11.00	01100	CAFETERIA	22	0	889,980	154,981	80,450	11.00
13.00	01300	NURSING ADMINISTRATION	76	0	1,782,253	310,362	30,136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,049	0	313,742	54,635	41,677	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	590,486	102,827	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	68,291	149,739	13,920,774	2,424,204	621,252	30.00
31.00	03100	INTENSIVE CARE UNIT	15,370	18,513	2,781,865	484,434	80,733	31.00
41.00	04100	SUBPROVIDER - IRF	9,932	88,775	5,059,950	881,140	344,977	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	129,764	549,307	6,170,170	1,074,473	294,116	50.00
51.00	05100	RECOVERY ROOM	2,365	43,443	1,031,534	179,631	21,480	51.00
53.00	05300	ANESTHESIOLOGY	10,216	81,253	951,431	165,682	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,333	213,678	4,444,699	774,000	179,853	54.00
56.00	05600	RADIOISOTOPE	1,009	153,403	1,813,933	315,878	29,909	56.00
57.00	05700	CT SCAN	9,099	536,432	1,815,465	316,145	19,236	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	455	114,788	915,177	159,369	14,596	58.00
60.00	06000	LABORATORY	9,841	535,445	7,084,031	1,233,613	128,803	60.00
65.00	06500	RESPIRATORY THERAPY	6,260	55,438	2,075,082	361,355	58,782	65.00
66.00	06600	PHYSICAL THERAPY	2,632	250,329	9,063,990	1,578,403	241,029	66.00
69.00	06900	ELECTROCARDIOLOGY	1,537	173,250	1,432,570	249,468	24,252	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	150,628	7,287,579	1,269,059	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	128,847	9,280,415	1,616,091	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356	240,055	7,554,714	1,315,578	38,301	73.00
76.97	07697	CARDIAC REHABILITATION	136	11,983	726,890	126,581	38,169	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	2,462	20,179	811,412	141,299	0	90.00
91.00	09100	EMERGENCY	34,404	241,415	5,780,970	1,006,698	184,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	313,441	3,756,900	116,324,336	17,244,107	2,597,481	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,884	2,940	20,197	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	84,893	14,783	0	192.00
192.01	19201	VACANT SPACE	0	0	220,203	38,346	263,414	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	313,441	3,756,900	116,646,316	17,300,176	2,881,092	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B  
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8/29/2016 11:28 am

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800	503,495					8.00
9.00	00900	0	2,025,348				9.00
10.00	01000	0	44,797	1,153,651			10.00
11.00	01100	0	57,823	0	1,183,234		11.00
13.00	01300	0	21,660	0	33,753	2,178,164	13.00
14.00	01400	0	29,955	0	4,985	0	14.00
16.00	01600	0	0	0	11,965	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	335,018	446,525	767,623	250,230	1,191,563	30.00
31.00	03100	37,975	58,027	87,011	53,388	371,712	31.00
41.00	04100	130,502	247,952	299,017	100,772	187,593	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	211,395	0	134,601	20,844	50.00
51.00	05100	0	15,439	0	22,393	0	51.00
53.00	05300	0	0	0	12,544	0	53.00
54.00	05400	0	129,269	0	62,239	0	54.00
56.00	05600	0	21,497	0	10,155	0	56.00
57.00	05700	0	13,826	0	14,365	0	57.00
58.00	05800	0	10,491	0	10,669	0	58.00
60.00	06000	0	92,577	0	58,317	0	60.00
65.00	06500	0	42,249	0	38,221	0	65.00
66.00	06600	0	173,240	0	157,614	0	66.00
69.00	06900	0	17,431	0	21,222	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	27,529	0	66,316	0	73.00
76.97	07697	0	27,434	0	14,589	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	6,215	0	90.00
91.00	09100	0	132,386	0	98,681	406,452	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		503,495	1,821,502	1,153,651	1,183,234	2,178,164	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	14,517	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	189,329	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		503,495	2,025,348	1,153,651	1,183,234	2,178,164	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B  
Part I  
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Cost Center Description		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
		14.00	16.00	17.00	19.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	444,994					14.00
16.00	01600	0	705,278				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	774	28,118	0	0	19,986,081	30.00
31.00	03100	161	3,476	0	0	3,958,782	31.00
41.00	04100	36	16,670	0	0	7,268,609	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	386,035	102,959	0	0	8,394,593	50.00
51.00	05100	0	8,158	0	0	1,278,635	51.00
53.00	05300	3,880	15,258	0	0	1,148,795	53.00
54.00	05400	5,395	40,124	0	0	5,635,579	54.00
56.00	05600	11,233	28,806	0	0	2,231,411	56.00
57.00	05700	405	100,731	0	0	2,280,173	57.00
58.00	05800	0	21,555	0	0	1,131,857	58.00
60.00	06000	25,880	100,545	0	0	8,723,766	60.00
65.00	06500	4,861	10,410	0	0	2,590,960	65.00
66.00	06600	29	47,006	0	0	11,261,311	66.00
69.00	06900	4,885	32,533	0	0	1,782,361	69.00
71.00	07100	61	28,285	0	0	8,584,984	71.00
72.00	07200	0	24,195	0	0	10,920,701	72.00
73.00	07300	38	45,077	0	0	9,047,553	73.00
76.97	07697	0	2,250	0	0	935,913	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	723	3,789	0	0	963,438	90.00
91.00	09100	598	45,333	0	0	7,655,308	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		444,994	705,278	0	0	115,780,810	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	54,538	190.00
192.00	19200	0	0	0	0	99,676	192.00
192.01	19201	0	0	0	0	711,292	192.01
192.02	19202	0	0	0	0	0	192.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		444,994	705,278	0	0	116,646,316	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00	
5.01	00550	DATA PROCESSING		5.01	
5.02	00560	PURCHASING RECEIVING AND STORES		5.02	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03	
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL		5.04	
6.00	00600	MAINTENANCE & REPAIRS		6.00	
8.00	00800	LAUNDRY & LINEN SERVICE		8.00	
9.00	00900	HOUSEKEEPING		9.00	
10.00	01000	DIETARY		10.00	
11.00	01100	CAFETERIA		11.00	
13.00	01300	NURSING ADMINISTRATION		13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00	
17.00	01700	SOCIAL SERVICE		17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	19,986,081	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,958,782	31.00
41.00	04100	SUBPROVIDER - I RF	0	7,268,609	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	8,394,593	50.00
51.00	05100	RECOVERY ROOM	0	1,278,635	51.00
53.00	05300	ANESTHESIOLOGY	0	1,148,795	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,635,579	54.00
56.00	05600	RADIOISOTOPE	0	2,231,411	56.00
57.00	05700	CT SCAN	0	2,280,173	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,131,857	58.00
60.00	06000	LABORATORY	0	8,723,766	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,590,960	65.00
66.00	06600	PHYSICAL THERAPY	0	11,261,311	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,782,361	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,584,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,920,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,047,553	73.00
76.97	07697	CARDIAC REHABILITATION	0	935,913	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	963,438	90.00
91.00	09100	EMERGENCY	0	7,655,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	115,780,810	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,538	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	99,676	192.00
192.01	19201	VACANT SPACE	0	711,292	192.01
192.02	19202	REFERENCE LAB	0	0	192.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	116,646,316	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet Non-CMS W  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	3	GROSS SALARIES	4.00
5.01	DATA PROCESSING	4	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	5	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	6	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	7	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	3	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	9	DIRECT NURSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	10	COSTED REQS	14.00
16.00	MEDICAL RECORDS & LIBRARY	6	GROSS REVENUE	16.00
17.00	SOCIAL SERVICE	7	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	11	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B  
Part II  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,303	5,037	30,340	30,340 4.00
5.01 00550	DATA PROCESSING	0	16,522	0	16,522	0 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	30,205	2,504	32,709	87 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	24,388	7,601	31,989	560 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	0	660,197	113,613	773,810	2,546 5.04
6.00 00600	MAINTENANCE & REPAIRS	0	376,337	15,848	392,185	414 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	632	632	29 8.00
9.00 00900	HOUSEKEEPING	0	52,844	20,249	73,093	673 9.00
10.00 01000	DIETARY	0	52,103	40,420	92,523	261 10.00
11.00 01100	CAFETERIA	0	67,253	0	67,253	472 11.00
13.00 01300	NURSING ADMINISTRATION	0	25,192	294,082	319,274	721 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	34,840	7,609	42,449	107 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	17,717	17,717	256 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	519,340	310,644	829,984	5,356 30.00
31.00 03100	INTENSIVE CARE UNIT	0	67,489	95,674	163,163	1,141 31.00
41.00 04100	SUBPROVIDER - IRF	0	288,386	97,637	386,023	2,154 41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	245,868	1,625,880	1,871,748	2,877 50.00
51.00 05100	RECOVERY ROOM	0	17,956	9,126	27,082	479 51.00
53.00 05300	ANESTHESIOLOGY	0	0	73,025	73,025	268 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	150,349	799,612	949,961	1,330 54.00
56.00 05600	RADIOISOTOPE	0	25,003	176,856	201,859	217 56.00
57.00 05700	CT SCAN	0	16,080	231,954	248,034	307 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	12,202	183,642	195,844	228 58.00
60.00 06000	LABORATORY	0	107,674	365,288	472,962	1,246 60.00
65.00 06500	RESPIRATORY THERAPY	0	49,139	107,782	156,921	817 65.00
66.00 06600	PHYSICAL THERAPY	0	201,490	95,592	297,082	3,369 66.00
69.00 06900	ELECTROCARDIOLOGY	0	20,274	175,875	196,149	454 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	32,018	54,895	86,913	1,417 73.00
76.97 07697	CARDIAC REHABILITATION	0	31,908	18,618	50,526	312 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	133 90.00
91.00 09100	EMERGENCY	0	153,975	220,939	374,914	2,109 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,304,335	5,168,351	8,472,686	30,340 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,884	0	16,884	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,438	3,438	0 192.00
192.01 19201	VACANT SPACE	0	220,203	0	220,203	0 192.01
192.02 19202	REFERENCE LAB	0	0	0	0	0 192.02
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	3,541,422	5,171,789	8,713,211	30,340 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140011		Period: From 04/01/2015 To 03/31/2016		Worksheet B Part II Date/Time Prepared: 8/29/2016 11:28 am	
Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	16,522					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	116	32,912				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	647	174	33,370			5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	901	1	0	777,258		5.04
6.00	00600	MAINTENANCE & REPAIRS	439	1	0	19,198	412,237	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	3,355	0	8.00
9.00	00900	HOUSEKEEPING	46	16	0	13,075	9,045	9.00
10.00	01000	DIETARY	185	1	0	6,974	8,918	10.00
11.00	01100	CAFETERIA	0	2	0	6,963	11,511	11.00
13.00	01300	NURSING ADMINISTRATION	277	8	0	13,944	4,312	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23	110	0	2,455	5,963	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	508	0	0	4,620	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,236	7,171	1,336	108,894	88,890	30.00
31.00	03100	INTENSIVE CARE UNIT	439	1,614	165	21,765	11,552	31.00
41.00	04100	SUBPROVIDER - IIRF	1,618	1,043	792	39,589	49,361	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	809	13,627	4,757	48,275	42,083	50.00
51.00	05100	RECOVERY ROOM	92	248	388	8,071	3,073	51.00
53.00	05300	ANESTHESIOLOGY	116	1,073	725	7,444	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	739	665	1,906	34,775	25,734	54.00
56.00	05600	RADIOISOTOPE	92	106	1,368	14,192	4,280	56.00
57.00	05700	CT SCAN	46	955	4,785	14,204	2,752	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23	48	1,024	7,160	2,089	58.00
60.00	06000	LABORATORY	924	1,033	4,776	55,425	18,430	60.00
65.00	06500	RESPIRATORY THERAPY	601	657	495	16,235	8,411	65.00
66.00	06600	PHYSICAL THERAPY	2,657	276	2,233	70,917	34,487	66.00
69.00	06900	ELECTROCARDIOLOGY	324	161	1,545	11,208	3,470	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,344	57,018	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,149	72,610	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	393	37	2,141	59,108	5,480	73.00
76.97	07697	CARDIAC REHABILITATION	231	14	107	5,687	5,461	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	254	259	180	6,348	0	90.00
91.00	09100	EMERGENCY	786	3,612	2,154	45,230	26,355	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,522	32,912	33,370	774,739	371,657	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	132	2,890	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	664	0	192.00
192.01	19201	VACANT SPACE	0	0	0	1,723	37,690	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	16,522	32,912	33,370	777,258	412,237	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B  
Part II  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
		8.00	9.00	10.00	11.00	13.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00550	DATA PROCESSING					5.01	
5.02	00560	PURCHASING RECEIVING AND STORES					5.02	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03	
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	4,016				8.00	
9.00	00900	HOUSEKEEPING	0	95,948			9.00	
10.00	01000	DIETARY	0	2,122	110,984		10.00	
11.00	01100	CAFETERIA	0	2,739	0	88,940	11.00	
13.00	01300	NURSING ADMINISTRATION	0	1,026	0	2,537	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,419	0	375	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	899	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,672	21,154	73,847	18,815	187,144	30.00
31.00	03100	INTENSIVE CARE UNIT	303	2,749	8,371	4,013	58,381	31.00
41.00	04100	SUBPROVIDER - I RF	1,041	11,746	28,766	7,574	29,463	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	10,015	0	10,117	3,274	50.00
51.00	05100	RECOVERY ROOM	0	731	0	1,683	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	943	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,124	0	4,678	0	54.00
56.00	05600	RADIOISOTOPE	0	1,018	0	763	0	56.00
57.00	05700	CT SCAN	0	655	0	1,080	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	497	0	802	0	58.00
60.00	06000	LABORATORY	0	4,386	0	4,383	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,001	0	2,873	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,207	0	11,846	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	826	0	1,595	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,304	0	4,984	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,300	0	1,096	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	467	0	90.00
91.00	09100	EMERGENCY	0	6,272	0	7,417	63,837	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,016	86,291	110,984	88,940	342,099	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	688	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VACANT SPACE	0	8,969	0	0	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	4,016	95,948	110,984	88,940	342,099	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet B Part II Date/Time Prepared: 8/29/2016 11:28 am	
Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal
	14.00	16.00	17.00	19.00	24.00
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01 00550	DATA PROCESSING				5.01
5.02 00560	PURCHASING RECEIVING AND STORES				5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE				5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL				5.04
6.00 00600	MAINTENANCE & REPAIRS				6.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	52,901			14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	24,000		16.00
17.00 01700	SOCIAL SERVICE	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	92	957	0	1,349,548
31.00 03100	INTENSIVE CARE UNIT	19	118	0	273,793
41.00 04100	SUBPROVIDER - IRF	4	568	0	559,742
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	45,893	3,494	0	2,056,969
51.00 05100	RECOVERY ROOM	0	278	0	42,125
53.00 05300	ANESTHESIOLOGY	461	519	0	84,574
54.00 05400	RADIOLOGY-DIAGNOSTIC	641	1,366	0	1,027,919
56.00 05600	RADIOISOTOPE	1,335	981	0	226,211
57.00 05700	CT SCAN	48	3,429	0	276,295
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	734	0	208,449
60.00 06000	LABORATORY	3,077	3,423	0	570,065
65.00 06500	RESPIRATORY THERAPY	578	354	0	189,943
66.00 06600	PHYSICAL THERAPY	3	1,600	0	432,677
69.00 06900	ELECTROCARDIOLOGY	581	1,108	0	217,421
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7	963	0	59,332
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	824	0	74,583
73.00 07300	DRUGS CHARGED TO PATIENTS	5	1,535	0	163,317
76.97 07697	CARDIAC REHABILITATION	0	77	0	64,811
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	86	129	0	7,856
91.00 09100	EMERGENCY	71	1,543	0	534,300
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 11300	INTEREST EXPENSE				
118.00	SUBTOTALS (SUM OF LINES 1-117)	52,901	24,000	0	8,419,930
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	20,594
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	4,102
192.01 19201	VACANT SPACE	0	0	0	268,585
192.02 19202	REFERENCE LAB	0	0	0	0
200.00	Cross Foot Adjustments			0	0
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118-201)	52,901	24,000	0	8,713,211

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet B Part II Date/Time Prepared: 8/29/2016 11:28 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00550	DATA PROCESSING		5.01
5.02	00560	PURCHASING RECEIVING AND STORES		5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL		5.04
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	1,349,548
31.00	03100	INTENSIVE CARE UNIT	0	273,793
41.00	04100	SUBPROVIDER - I RF	0	559,742
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	2,056,969
51.00	05100	RECOVERY ROOM	0	42,125
53.00	05300	ANESTHESIOLOGY	0	84,574
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,027,919
56.00	05600	RADIOISOTOPE	0	226,211
57.00	05700	CT SCAN	0	276,295
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	208,449
60.00	06000	LABORATORY	0	570,065
65.00	06500	RESPIRATORY THERAPY	0	189,943
66.00	06600	PHYSICAL THERAPY	0	432,677
69.00	06900	ELECTROCARDIOLOGY	0	217,421
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	59,332
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	74,583
73.00	07300	DRUGS CHARGED TO PATIENTS	0	163,317
76.97	07697	CARDIAC REHABILITATION	0	64,811
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	7,856
91.00	09100	EMERGENCY	0	534,300
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	8,419,930
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,594
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,102
192.01	19201	VACANT SPACE	0	268,585
192.02	19202	REFERENCE LAB	0	0
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	8,713,211

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B-1

Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	224,641				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,584,227			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,605	2,517	41,665,210		4.00
5.01 00550	DATA PROCESSING	1,048	0	0	715	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	1,916	1,251	119,801	5	5,136,089 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,547	3,798	768,882	28	27,091 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	41,878	56,770	3,497,120	39	153 5.04
6.00 00600	MAINTENANCE & REPAIRS	23,872	7,919	569,338	19	93 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	316	39,799	0	0 8.00
9.00 00900	HOUSEKEEPING	3,352	10,118	924,324	2	2,486 9.00
10.00 01000	DIETARY	3,305	20,197	358,499	8	202 10.00
11.00 01100	CAFETERIA	4,266	0	648,291	0	366 11.00
13.00 01300	NURSING ADMINISTRATION	1,598	146,946	990,967	12	1,245 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,210	3,802	146,349	1	17,194 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	8,853	351,274	22	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	32,943	155,222	7,347,004	140	1,119,026 30.00
31.00 03100	INTENSIVE CARE UNIT	4,281	47,806	1,567,421	19	251,848 31.00
41.00 04100	SUBPROVIDER - I/R	18,293	48,787	2,958,578	70	162,747 41.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	15,596	812,416	3,951,769	35	2,126,339 50.00
51.00 05100	RECOVERY ROOM	1,139	4,560	657,434	4	38,756 51.00
53.00 05300	ANESTHESIOLOGY	0	36,489	368,270	5	167,394 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,537	399,548	1,827,280	32	103,768 54.00
56.00 05600	RADIOISOTOPE	1,586	88,371	298,133	4	16,530 56.00
57.00 05700	CT SCAN	1,020	115,902	421,755	2	149,103 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	774	91,762	313,231	1	7,458 58.00
60.00 06000	LABORATORY	6,830	182,526	1,712,137	40	161,251 60.00
65.00 06500	RESPIRATORY THERAPY	3,117	53,856	1,122,146	26	102,579 65.00
66.00 06600	PHYSICAL THERAPY	12,781	47,765	4,627,391	115	43,131 66.00
69.00 06900	ELECTROCARDIOLOGY	1,286	87,881	623,073	14	25,186 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,031	27,430	1,946,978	17	5,830 73.00
76.97 07697	CARDIAC REHABILITATION	2,024	9,303	428,320	10	2,226 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	182,469	11	40,343 90.00
91.00 09100	EMERGENCY	9,767	110,398	2,897,177	34	563,744 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	209,602	2,582,509	41,665,210	715	5,136,089 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,071	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	1,718	0	0	0 192.00
192.01 19201	VACANT SPACE	13,968	0	0	0	0 192.01
192.02 19202	REFERENCE LAB	0	0	0	0	0 192.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	3,541,422	5,171,789	14,246,517	4,849,594	313,441 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15.764807	2.001291	0.341928	6,782.648951	0.061027 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			30,340	16,522	32,912 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000728	23.107692	0.006408 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period: From 04/01/2015 To 03/31/2016

Worksheet B-1

Date/Time Prepared: 8/29/2016 11:28 am

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)		
		5.03	5A.04	5.04	6.00	8.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00550	DATA PROCESSING					5.01	
5.02	00560	PURCHASING RECEIVING AND STORES					5.02	
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	558,589,618				5.03	
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	0	-17,300,176	99,346,140		5.04	
6.00	00600	MAINTENANCE & REPAIRS	0	0	2,453,789	152,775	6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	428,820	0	8.00	
9.00	00900	HOUSEKEEPING	0	0	1,671,125	3,352	9.00	
10.00	01000	DIETARY	0	0	891,314	3,305	10.00	
11.00	01100	CAFETERIA	0	0	889,980	4,266	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	1,782,253	1,598	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	313,742	2,210	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	590,486	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	22,262,719	0	13,920,774	32,943	18,350	30.00
31.00	03100	INTENSIVE CARE UNIT	2,752,506	0	2,781,865	4,281	2,080	31.00
41.00	04100	SUBPROVIDER - IIRF	13,198,814	0	5,059,950	18,293	7,148	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	81,694,872	0	6,170,170	15,596	0	50.00
51.00	05100	RECOVERY ROOM	6,458,903	0	1,031,534	1,139	0	51.00
53.00	05300	ANESTHESIOLOGY	12,080,479	0	951,431	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,768,996	0	4,444,699	9,537	0	54.00
56.00	05600	RADIOISOTOPE	22,807,467	0	1,813,933	1,586	0	56.00
57.00	05700	CT SCAN	79,754,996	0	1,815,465	1,020	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,066,258	0	915,177	774	0	58.00
60.00	06000	LABORATORY	79,608,253	0	7,084,031	6,830	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,242,412	0	2,075,082	3,117	0	65.00
66.00	06600	PHYSICAL THERAPY	37,218,050	0	9,063,990	12,781	0	66.00
69.00	06900	ELECTROCARDIOLOGY	25,758,270	0	1,432,570	1,286	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,394,883	0	7,287,579	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,156,625	0	9,280,415	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,690,557	0	7,554,714	2,031	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,781,591	0	726,890	2,024	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3,000,095	0	811,412	0	0	90.00
91.00	09100	EMERGENCY	35,892,872	0	5,780,970	9,767	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	558,589,618	-17,300,176	99,024,160	137,736	27,578	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	16,884	1,071	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	84,893	0	0	192.00
192.01	19201	VACANT SPACE	0	0	220,203	13,968	0	192.01
192.02	19202	REFERENCE LAB	0	0	0	0	0	192.02
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)	3,756,900		17,300,176	2,881,092	503,495	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006726		0.174140	18.858400	18.257125	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33,370		777,258	412,237	4,016	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000060		0.007824	2.698328	0.145623	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B-1

Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQS)	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	149,423					9.00
10.00	01000	3,305	82,734				10.00
11.00	01100	4,266	0	34,739,156			11.00
13.00	01300	1,598	0	990,967	9,405		13.00
14.00	01400	2,210	0	146,349	0	7,576,592	14.00
16.00	01600	0	0	351,274	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	32,943	55,050	7,347,004	5,145	13,186	30.00
31.00	03100	4,281	6,240	1,567,421	1,605	2,744	31.00
41.00	04100	18,293	21,444	2,958,578	810	605	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	15,596	0	3,951,769	90	6,572,726	50.00
51.00	05100	1,139	0	657,434	0	0	51.00
53.00	05300	0	0	368,270	0	66,056	53.00
54.00	05400	9,537	0	1,827,280	0	91,855	54.00
56.00	05600	1,586	0	298,133	0	191,256	56.00
57.00	05700	1,020	0	421,755	0	6,902	57.00
58.00	05800	774	0	313,231	0	0	58.00
60.00	06000	6,830	0	1,712,137	0	440,637	60.00
65.00	06500	3,117	0	1,122,146	0	82,767	65.00
66.00	06600	12,781	0	4,627,391	0	489	66.00
69.00	06900	1,286	0	623,073	0	83,176	69.00
71.00	07100	0	0	0	0	1,040	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,031	0	1,946,978	0	650	73.00
76.97	07697	2,024	0	428,320	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	182,469	0	12,317	90.00
91.00	09100	9,767	0	2,897,177	1,755	10,186	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		134,384	82,734	34,739,156	9,405	7,576,592	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,071	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	13,968	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
200.00							200.00
201.00							201.00
202.00		2,025,348	1,153,651	1,183,234	2,178,164	444,994	202.00
203.00		13.554459	13.944098	0.034061	231.596385	0.058733	203.00
204.00		95,948	110,984	88,940	342,099	52,901	204.00
205.00		0.642123	1.341456	0.002560	36.374163	0.006982	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet B-1  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		16.00	17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00580				5.03
5.04	00590				5.04
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600	558,589,618			16.00
17.00	01700	0	27,578		17.00
19.00	01900	0	0	100	19.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	22,262,719	18,350	0	30.00
31.00	03100	2,752,506	2,080	0	31.00
41.00	04100	13,198,814	7,148	0	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	81,694,872	0	0	50.00
51.00	05100	6,458,903	0	0	51.00
53.00	05300	12,080,479	0	100	53.00
54.00	05400	31,768,996	0	0	54.00
56.00	05600	22,807,467	0	0	56.00
57.00	05700	79,754,996	0	0	57.00
58.00	05800	17,066,258	0	0	58.00
60.00	06000	79,608,253	0	0	60.00
65.00	06500	8,242,412	0	0	65.00
66.00	06600	37,218,050	0	0	66.00
69.00	06900	25,758,270	0	0	69.00
71.00	07100	22,394,883	0	0	71.00
72.00	07200	19,156,625	0	0	72.00
73.00	07300	35,690,557	0	0	73.00
76.97	07697	1,781,591	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	3,000,095	0	0	90.00
91.00	09100	35,892,872	0	0	91.00
92.00	09200				92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		558,589,618	27,578	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
192.02	19202	0	0	0	192.02
200.00					200.00
201.00					201.00
202.00		705,278	0	0	202.00
203.00		0.001263	0.000000	0.000000	203.00
204.00		24,000	0	0	204.00
205.00		0.000043	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	19,986,081		19,986,081	0	19,986,081	30.00
31.00	03100 INTENSIVE CARE UNIT	3,958,782		3,958,782	0	3,958,782	31.00
41.00	04100 SUBPROVIDER - I RF	7,268,609		7,268,609	0	7,268,609	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	8,394,593		8,394,593	20,234	8,414,827	50.00
51.00	05100 RECOVERY ROOM	1,278,635		1,278,635	0	1,278,635	51.00
53.00	05300 ANESTHESIOLOGY	1,148,795		1,148,795	0	1,148,795	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,635,579		5,635,579	0	5,635,579	54.00
56.00	05600 RADIOISOTOPE	2,231,411		2,231,411	0	2,231,411	56.00
57.00	05700 CT SCAN	2,280,173		2,280,173	0	2,280,173	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,131,857		1,131,857	0	1,131,857	58.00
60.00	06000 LABORATORY	8,723,766		8,723,766	6,400	8,730,166	60.00
65.00	06500 RESPIRATORY THERAPY	2,590,960	0	2,590,960	15,267	2,606,227	65.00
66.00	06600 PHYSICAL THERAPY	11,261,311	0	11,261,311	0	11,261,311	66.00
69.00	06900 ELECTROCARDIOLOGY	1,782,361		1,782,361	1,089	1,783,450	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,584,984		8,584,984	0	8,584,984	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,920,701		10,920,701	0	10,920,701	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9,047,553		9,047,553	0	9,047,553	73.00
76.97	07697 CARDIAC REHABILITATION	935,913		935,913	1,740	937,653	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	963,438		963,438	389	963,827	90.00
91.00	09100 EMERGENCY	7,655,308		7,655,308	6,756	7,662,064	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,157,857		2,157,857		2,157,857	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	117,938,667	0	117,938,667	51,875	117,990,542	200.00
201.00	Less Observation Beds	2,157,857		2,157,857		2,157,857	201.00
202.00	Total (see instructions)	115,780,810	0	115,780,810	51,875	115,832,685	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,514,746		18,514,746		30.00
31.00	03100	INTENSIVE CARE UNIT	2,752,506		2,752,506		31.00
41.00	04100	SUBPROVIDER - IRF	11,919,271		11,919,271		41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,495,948	45,270,299	80,766,247	0.103937	50.00
51.00	05100	RECOVERY ROOM	3,609,904	2,598,012	6,207,916	0.205968	51.00
53.00	05300	ANESTHESIOLOGY	5,293,971	6,621,442	11,915,413	0.096413	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,814,831	26,508,010	31,322,841	0.179919	54.00
56.00	05600	RADIOISOTOPE	2,667,035	19,943,618	22,610,653	0.098688	56.00
57.00	05700	CT SCAN	17,243,149	61,889,037	79,132,186	0.028815	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,521,563	14,222,746	16,744,309	0.067597	58.00
60.00	06000	LABORATORY	20,804,142	58,467,314	79,271,456	0.110049	60.00
65.00	06500	RESPIRATORY THERAPY	6,179,094	2,033,299	8,212,393	0.315494	65.00
66.00	06600	PHYSICAL THERAPY	10,835,025	25,830,865	36,665,890	0.307133	66.00
69.00	06900	ELECTROCARDIOLOGY	7,615,865	16,374,392	23,990,257	0.074295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,891,466	7,307,849	22,199,315	0.386723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,059,960	4,036,008	19,095,968	0.571885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,819,073	12,711,006	35,530,079	0.254645	73.00
76.97	07697	CARDIAC REHABILITATION	670	1,780,921	1,781,591	0.525324	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,187	2,983,571	2,996,758	0.321493	90.00
91.00	09100	EMERGENCY	7,932,015	27,761,311	35,693,326	0.214474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	523,426	3,190,318	3,713,744	0.581046	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	211,506,847	339,530,018	551,036,865		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	211,506,847	339,530,018	551,036,865		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet C Part I Date/Time Prepared: 8/29/2016 11:28 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.104187		50.00
51.00	05100 RECOVERY ROOM	0.205968		51.00
53.00	05300 ANESTHESIOLOGY	0.096413		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.179919		54.00
56.00	05600 RADIOISOTOPE	0.098688		56.00
57.00	05700 CT SCAN	0.028815		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.067597		58.00
60.00	06000 LABORATORY	0.110130		60.00
65.00	06500 RESPIRATORY THERAPY	0.317353		65.00
66.00	06600 PHYSICAL THERAPY	0.307133		66.00
69.00	06900 ELECTROCARDIOLOGY	0.074341		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386723		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.571885		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254645		73.00
76.97	07697 CARDIAC REHABILITATION	0.526301		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.321623		90.00
91.00	09100 EMERGENCY	0.214664		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.581046		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	19,986,081		19,986,081	0	19,986,081	30.00
31.00	03100 INTENSIVE CARE UNIT	3,958,782		3,958,782	0	3,958,782	31.00
41.00	04100 SUBPROVIDER - I RF	7,268,609		7,268,609	0	7,268,609	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	8,394,593		8,394,593	20,234	8,414,827	50.00
51.00	05100 RECOVERY ROOM	1,278,635		1,278,635	0	1,278,635	51.00
53.00	05300 ANESTHESIOLOGY	1,148,795		1,148,795	0	1,148,795	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,635,579		5,635,579	0	5,635,579	54.00
56.00	05600 RADIOISOTOPE	2,231,411		2,231,411	0	2,231,411	56.00
57.00	05700 CT SCAN	2,280,173		2,280,173	0	2,280,173	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,131,857		1,131,857	0	1,131,857	58.00
60.00	06000 LABORATORY	8,723,766		8,723,766	6,400	8,730,166	60.00
65.00	06500 RESPIRATORY THERAPY	2,590,960	0	2,590,960	15,267	2,606,227	65.00
66.00	06600 PHYSICAL THERAPY	11,261,311	0	11,261,311	0	11,261,311	66.00
69.00	06900 ELECTROCARDIOLOGY	1,782,361		1,782,361	1,089	1,783,450	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,584,984		8,584,984	0	8,584,984	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10,920,701		10,920,701	0	10,920,701	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	9,047,553		9,047,553	0	9,047,553	73.00
76.97	07697 CARDIAC REHABILITATION	935,913		935,913	1,740	937,653	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	963,438		963,438	389	963,827	90.00
91.00	09100 EMERGENCY	7,655,308		7,655,308	6,756	7,662,064	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,157,857		2,157,857		2,157,857	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	117,938,667	0	117,938,667	51,875	117,990,542	200.00
201.00	Less Observation Beds	2,157,857		2,157,857		2,157,857	201.00
202.00	Total (see instructions)	115,780,810	0	115,780,810	51,875	115,832,685	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet C  
Part I  
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,514,746		18,514,746		30.00
31.00	03100	INTENSIVE CARE UNIT	2,752,506		2,752,506		31.00
41.00	04100	SUBPROVIDER - IRF	11,919,271		11,919,271		41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	35,495,948	45,270,299	80,766,247	0.103937	50.00
51.00	05100	RECOVERY ROOM	3,609,904	2,598,012	6,207,916	0.205968	51.00
53.00	05300	ANESTHESIOLOGY	5,293,971	6,621,442	11,915,413	0.096413	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,814,831	26,508,010	31,322,841	0.179919	54.00
56.00	05600	RADIOISOTOPE	2,667,035	19,943,618	22,610,653	0.098688	56.00
57.00	05700	CT SCAN	17,243,149	61,889,037	79,132,186	0.028815	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,521,563	14,222,746	16,744,309	0.067597	58.00
60.00	06000	LABORATORY	20,804,142	58,467,314	79,271,456	0.110049	60.00
65.00	06500	RESPIRATORY THERAPY	6,179,094	2,033,299	8,212,393	0.315494	65.00
66.00	06600	PHYSICAL THERAPY	10,835,025	25,830,865	36,665,890	0.307133	66.00
69.00	06900	ELECTROCARDIOLOGY	7,615,865	16,374,392	23,990,257	0.074295	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,891,466	7,307,849	22,199,315	0.386723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,059,960	4,036,008	19,095,968	0.571885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,819,073	12,711,006	35,530,079	0.254645	73.00
76.97	07697	CARDIAC REHABILITATION	670	1,780,921	1,781,591	0.525324	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	13,187	2,983,571	2,996,758	0.321493	90.00
91.00	09100	EMERGENCY	7,932,015	27,761,311	35,693,326	0.214474	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	523,426	3,190,318	3,713,744	0.581046	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	211,506,847	339,530,018	551,036,865		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	211,506,847	339,530,018	551,036,865		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet C  
Part I  
Date/Time Prepared:  
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140011		Period: From 04/01/2015 To 03/31/2016		Worksheet D Part I Date/Time Prepared: 8/29/2016 11:28 am		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,349,548	0	1,349,548	20,571	65.60	30.00	
31.00	INTENSIVE CARE UNIT	273,793		273,793	2,080	131.63	31.00	
41.00	SUBPROVIDER - IRF	559,742	0	559,742	7,148	78.31	41.00	
200.00	Total (Lines 30-199)	2,183,083		2,183,083	29,799		200.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
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	11,236	737,082					30.00
31.00	INTENSIVE CARE UNIT	1,103	145,188					31.00
41.00	SUBPROVIDER - IRF	4,754	372,286					41.00
200.00	Total (Lines 30-199)	17,093	1,254,556					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part II Date/Time Prepared: 8/29/2016 11:28 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,056,969	80,766,247	0.025468	16,036,010	408,405	50.00
51.00	05100 RECOVERY ROOM	42,125	6,207,916	0.006786	1,474,855	10,008	51.00
53.00	05300 ANESTHESIOLOGY	84,574	11,915,413	0.007098	2,318,986	16,460	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,027,919	31,322,841	0.032817	2,674,257	87,761	54.00
56.00	05600 RADIOISOTOPE	226,211	22,610,653	0.010005	1,746,765	17,476	56.00
57.00	05700 CT SCAN	276,295	79,132,186	0.003492	10,785,730	37,664	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	208,449	16,744,309	0.012449	1,320,746	16,442	58.00
60.00	06000 LABORATORY	570,065	79,271,456	0.007191	12,220,327	87,876	60.00
65.00	06500 RESPIRATORY THERAPY	189,943	8,212,393	0.023129	3,420,340	79,109	65.00
66.00	06600 PHYSICAL THERAPY	432,677	36,665,890	0.011801	1,962,487	23,159	66.00
69.00	06900 ELECTROCARDIOLOGY	217,421	23,990,257	0.009063	5,022,102	45,515	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59,332	22,199,315	0.002673	4,649,765	12,429	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	74,583	19,095,968	0.003906	7,449,236	29,097	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	163,317	35,530,079	0.004597	11,489,028	52,815	73.00
76.97	07697 CARDIAC REHABILITATION	64,811	1,781,591	0.036378	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	7,856	2,996,758	0.002621	4,128	11	90.00
91.00	09100 EMERGENCY	534,300	35,693,326	0.014969	4,120,650	61,682	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	145,707	3,713,744	0.039235	304,440	11,945	92.00
200.00	Total (lines 50-199)	6,382,554	517,850,342		86,999,852	997,854	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part III Date/Time Prepared: 8/29/2016 11:28 am
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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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
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)	PSA Adj. Nursing School		
		6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,571	0.00	11,236	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,080	0.00	1,103	0	31.00	
41.00	04100	SUBPROVIDER - IRF	7,148	0.00	4,754	0	41.00	
200.00		Total (lines 30-199)	29,799		17,093	0	200.00	
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
		12.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
41.00	04100	SUBPROVIDER - IRF	0	0				41.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet D  
Part IV  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet D  
Part IV  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	80,766,247	0.000000	0.000000	16,036,010	50.00
51.00	05100	RECOVERY ROOM	0	6,207,916	0.000000	0.000000	1,474,855	51.00
53.00	05300	ANESTHESIOLOGY	0	11,915,413	0.000000	0.000000	2,318,986	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,322,841	0.000000	0.000000	2,674,257	54.00
56.00	05600	RADIOISOTOPE	0	22,610,653	0.000000	0.000000	1,746,765	56.00
57.00	05700	CT SCAN	0	79,132,186	0.000000	0.000000	10,785,730	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	16,744,309	0.000000	0.000000	1,320,746	58.00
60.00	06000	LABORATORY	0	79,271,456	0.000000	0.000000	12,220,327	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,212,393	0.000000	0.000000	3,420,340	65.00
66.00	06600	PHYSICAL THERAPY	0	36,665,890	0.000000	0.000000	1,962,487	66.00
69.00	06900	ELECTROCARDIOLOGY	0	23,990,257	0.000000	0.000000	5,022,102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,199,315	0.000000	0.000000	4,649,765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,095,968	0.000000	0.000000	7,449,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,530,079	0.000000	0.000000	11,489,028	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,781,591	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,996,758	0.000000	0.000000	4,128	90.00
91.00	09100	EMERGENCY	0	35,693,326	0.000000	0.000000	4,120,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,713,744	0.000000	0.000000	304,440	92.00
200.00		Total (lines 50-199)	0	517,850,342			86,999,852	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part IV Date/Time Prepared: 8/29/2016 11:28 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	13,536,995	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	868,858	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	1,904,834	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,238,010	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	8,633,162	0	0	0	56.00
57.00	05700 CT SCAN	0	20,149,562	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4,234,083	0	0	0	58.00
60.00	06000 LABORATORY	0	7,872,075	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	805,508	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	14,084	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	6,845,203	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,787,596	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,416,742	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,766,893	0	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	631,846	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	1,616,514	0	0	0	90.00
91.00	09100 EMERGENCY	0	6,879,248	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,254,806	0	0	0	92.00
200.00	Total (lines 50-199)	0	89,456,019	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part IV Date/Time Prepared: 8/29/2016 11:28 am
	Title XVIII	Hospital	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part V Date/Time Prepared: 8/29/2016 11:28 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.103937	13,536,995	0	0	1,406,995	50.00
51.00	05100 RECOVERY ROOM	0.205968	868,858	0	0	178,957	51.00
53.00	05300 ANESTHESIOLOGY	0.096413	1,904,834	0	0	183,651	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.179919	7,238,010	0	0	1,302,256	54.00
56.00	05600 RADIOISOTOPE	0.098688	8,633,162	0	0	851,989	56.00
57.00	05700 CT SCAN	0.028815	20,149,562	0	0	580,610	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.067597	4,234,083	0	0	286,211	58.00
60.00	06000 LABORATORY	0.110049	7,872,075	6,948	0	866,314	60.00
65.00	06500 RESPIRATORY THERAPY	0.315494	805,508	0	0	254,133	65.00
66.00	06600 PHYSICAL THERAPY	0.307133	14,084	0	0	4,326	66.00
69.00	06900 ELECTROCARDIOLOGY	0.074295	6,845,203	0	0	508,564	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386723	1,787,596	0	0	691,304	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.571885	1,416,742	0	0	810,213	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254645	3,766,893	0	32,825	959,220	73.00
76.97	07697 CARDIAC REHABILITATION	0.525324	631,846	0	0	331,924	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.321493	1,616,514	0	0	519,698	90.00
91.00	09100 EMERGENCY	0.214474	6,879,248	0	0	1,475,420	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.581046	1,254,806	0	0	729,100	92.00
200.00	Subtotal (see instructions)		89,456,019	6,948	32,825	11,940,885	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		89,456,019	6,948	32,825	11,940,885	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part V Date/Time Prepared: 8/29/2016 11:28 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	765	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,359	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	765	8,359	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	765	8,359	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140011 Component CCN: 14T011		Period: From 04/01/2015 To 03/31/2016		Worksheet D Part II Date/Time Prepared: 8/29/2016 11:28 am		
				Title XVIII		Subprovider - IRF	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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,056,969	80,766,247	0.025468	36,014	917	50.00
51.00	05100	RECOVERY ROOM	42,125	6,207,916	0.006786	0	0	51.00
53.00	05300	ANESTHESIOLOGY	84,574	11,915,413	0.007098	1,219	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,027,919	31,322,841	0.032817	187,917	6,167	54.00
56.00	05600	RADIOISOTOPE	226,211	22,610,653	0.010005	3,222	32	56.00
57.00	05700	CT SCAN	276,295	79,132,186	0.003492	243,278	850	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	208,449	16,744,309	0.012449	57,260	713	58.00
60.00	06000	LABORATORY	570,065	79,271,456	0.007191	963,964	6,932	60.00
65.00	06500	RESPIRATORY THERAPY	189,943	8,212,393	0.023129	312,901	7,237	65.00
66.00	06600	PHYSICAL THERAPY	432,677	36,665,890	0.011801	5,121,470	60,438	66.00
69.00	06900	ELECTROCARDIOLOGY	217,421	23,990,257	0.009063	79,404	720	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,332	22,199,315	0.002673	5,267	14	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,583	19,095,968	0.003906	9,423	37	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,317	35,530,079	0.004597	1,474,743	6,779	73.00
76.97	07697	CARDIAC REHABILITATION	64,811	1,781,591	0.036378	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	7,856	2,996,758	0.002621	246	1	90.00
91.00	09100	EMERGENCY	534,300	35,693,326	0.014969	260	4	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,713,744	0.000000	0	0	92.00
200.00		Total (lines 50-199)	6,236,847	517,850,342		8,496,588	90,850	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part IV Date/Time Prepared: 8/29/2016 11:28 am
	Title XVIII	Subprovider - IRF	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
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
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140011 Component CCN: 14T011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part IV Date/Time Prepared: 8/29/2016 11:28 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	80,766,247	0.000000	0.000000	36,014 50.00
51.00 05100 RECOVERY ROOM	0	6,207,916	0.000000	0.000000	0 51.00
53.00 05300 ANESTHESIOLOGY	0	11,915,413	0.000000	0.000000	1,219 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	31,322,841	0.000000	0.000000	187,917 54.00
56.00 05600 RADIOISOTOPE	0	22,610,653	0.000000	0.000000	3,222 56.00
57.00 05700 CT SCAN	0	79,132,186	0.000000	0.000000	243,278 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	16,744,309	0.000000	0.000000	57,260 58.00
60.00 06000 LABORATORY	0	79,271,456	0.000000	0.000000	963,964 60.00
65.00 06500 RESPIRATORY THERAPY	0	8,212,393	0.000000	0.000000	312,901 65.00
66.00 06600 PHYSICAL THERAPY	0	36,665,890	0.000000	0.000000	5,121,470 66.00
69.00 06900 ELECTROCARDIOLOGY	0	23,990,257	0.000000	0.000000	79,404 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,199,315	0.000000	0.000000	5,267 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	19,095,968	0.000000	0.000000	9,423 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	35,530,079	0.000000	0.000000	1,474,743 73.00
76.97 07697 CARDIAC REHABILITATION	0	1,781,591	0.000000	0.000000	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	2,996,758	0.000000	0.000000	246 90.00
91.00 09100 EMERGENCY	0	35,693,326	0.000000	0.000000	260 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,713,744	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	517,850,342			8,496,588 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part IV Date/Time Prepared: 8/29/2016 11:28 am
	Title XVIII	Subprovider - IRF	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
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
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140011 Component CCN: 14T011	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part IV Date/Time Prepared: 8/29/2016 11:28 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (Lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D-1 Date/Time Prepared: 8/29/2016 11:28 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		20,571	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,571	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)		18,350	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)		11,236	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
<b>SWING BED ADJUSTMENT</b>				
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)		19,986,081	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)		19,986,081	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		19,986,081	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		971.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,916,561	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		10,916,561	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011		Period: From 04/01/2015 To 03/31/2016		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 8/29/2016 11:28 am	
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)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,958,782	2,080	1,903.26	1,103	2,099,296		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)					16,705,752		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					29,721,609		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)					882,270		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					997,854		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,880,124		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					27,841,485		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)					2,221		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					971.57		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,157,857		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011		Period: From 04/01/2015 To 03/31/2016		Worksheet D-1 Date/Time Prepared: 8/29/2016 11:28 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,349,548	19,986,081	0.067524	2,157,857	145,707	90.00
91.00	Nursing School cost	0	19,986,081	0.000000	2,157,857	0	91.00
92.00	Allied health cost	0	19,986,081	0.000000	2,157,857	0	92.00
93.00	All other Medical Education	0	19,986,081	0.000000	2,157,857	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D-1
		Component CCN: 14T011		Date/Time Prepared: 8/29/2016 11:28 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,148	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)		7,148	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)		4,754	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
<b>SWING BED ADJUSTMENT</b>				
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)		7,268,609	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)		7,268,609	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		7,268,609	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,016.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,834,200	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)		4,834,200	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D-1			
		Component CCN: 14T011		Date/Time Prepared: 8/29/2016 11:28 am			
		Title XVIII	Subprovider - IRF	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	0	0	0.00	0	0	43.00	
44.00	INTENSIVE CARE UNIT					44.00	
45.00	CORONARY CARE UNIT					45.00	
46.00	BURN INTENSIVE CARE UNIT					46.00	
47.00	SURGICAL INTENSIVE CARE UNIT					47.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
	Cost Center Description						
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,216,312	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,050,512	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)					372,286	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					90,850	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					463,136	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					6,587,376	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: 140011 Component CCN: 14T011		Period: From 04/01/2015 To 03/31/2016		Worksheet D-1 Date/Time Prepared: 8/29/2016 11:28 am	
		Title XVIII		Subprovider - IRF		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	559,742	7,268,609	0.077008	0	0	90.00
91.00	Nursing School cost	0	7,268,609	0.000000	0	0	91.00
92.00	Allied health cost	0	7,268,609	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,268,609	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet D-3 Date/Time Prepared: 8/29/2016 11:28 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		9,620,249	30.00
31.00	03100	INTENSIVE CARE UNIT		1,508,904	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.104187	16,036,010	50.00
51.00	05100	RECOVERY ROOM	0.205968	1,474,855	51.00
53.00	05300	ANESTHESIOLOGY	0.096413	2,318,986	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.179919	2,674,257	54.00
56.00	05600	RADIOISOTOPE	0.098688	1,746,765	56.00
57.00	05700	CT SCAN	0.028815	10,785,730	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067597	1,320,746	58.00
60.00	06000	LABORATORY	0.110130	12,220,327	60.00
65.00	06500	RESPIRATORY THERAPY	0.317353	3,420,340	65.00
66.00	06600	PHYSICAL THERAPY	0.307133	1,962,487	66.00
69.00	06900	ELECTROCARDIOLOGY	0.074341	5,022,102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386723	4,649,765	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.571885	7,449,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.254645	11,489,028	73.00
76.97	07697	CARDIAC REHABILITATION	0.526301	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.321623	4,128	90.00
91.00	09100	EMERGENCY	0.214664	4,120,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.581046	304,440	92.00
200.00		Total (sum of lines 50-94 and 96-98)		86,999,852	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)		86,999,852	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2015 To 03/31/2016	Worksheet D-3 Date/Time Prepared: 8/29/2016 11:28 am
		Title XVIII	Subprovider - IRF	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		7,941,910	41.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.104187	36,014	50.00
51.00	05100 RECOVERY ROOM	0.205968	0	51.00
53.00	05300 ANESTHESIOLOGY	0.096413	1,219	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.179919	187,917	54.00
56.00	05600 RADIOISOTOPE	0.098688	3,222	56.00
57.00	05700 CT SCAN	0.028815	243,278	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.067597	57,260	58.00
60.00	06000 LABORATORY	0.110130	963,964	60.00
65.00	06500 RESPIRATORY THERAPY	0.317353	312,901	65.00
66.00	06600 PHYSICAL THERAPY	0.307133	5,121,470	66.00
69.00	06900 ELECTROCARDIOLOGY	0.074341	79,404	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386723	5,267	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.571885	9,423	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.254645	1,474,743	73.00
76.97	07697 CARDIAC REHABILITATION	0.526301	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.321623	246	90.00
91.00	09100 EMERGENCY	0.214664	260	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.581046	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		8,496,588	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)		8,496,588	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/29/2016 11:28 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		11,306,272	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,298,855	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		156,679	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		78.93	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.69	30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.43	31.00
32.00	Sum of lines 30 and 31		24.12	32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.11	33.00
34.00	Disproportionate share adjustment (see instructions)		514,832	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/29/2016 11:28 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	0	35.00
35.01	Factor 3 (see instructions)		0.000066987	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		512,293	510,145	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		256,848	255,073	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		511,921		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		23,788,559		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		27,928,204		48.00
				<b>Amount</b>	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			26,893,293	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,795,158	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			28,688,451	59.00
60.00	Primary payer payments			14,690	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			28,673,761	61.00
62.00	Deductibles billed to program beneficiaries			2,748,676	62.00
63.00	Coinurance billed to program beneficiaries			46,949	63.00
64.00	Allowable bad debts (see instructions)			822,999	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			534,949	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			655,065	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			26,413,085	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	RURAL DEMONSTRATION PROJECT			0	70.50
70.88	SCH or MDH volume decrease adjustment			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			22,615	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-38,343	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			164,610	70.93
70.94	HRR adjustment amount (see instructions)			-279,164	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/29/2016 11:28 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			26,282,803	71.00
71.01	Sequestration adjustment (see instructions)			525,656	71.01
72.00	Interim payments			26,820,256	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			-1,063,109	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			49,058	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)		1,552,367	1,552,367	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)		1.0013901163	1.0131777191	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		2,158	20,457	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)		0.9890	0.9863	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-17,076	-21,267	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011		Period: From 04/01/2015 To 03/31/2016		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 8/29/2016 11:28 am	
		PPS					
		Original .mcx Values	Adjusted .mcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF THE DSH PAYMENT PERCENTAGE</b>							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	7.69	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	16.43	0.00			16.43	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	24.12	0.00			16.43	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	MDH				MDH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	78.93	0.00			78.93	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	9.11	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	5.23	0.00	0.00	0.00	0.00	14.00
<b>CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS</b>							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	3,056	0			3,056	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	73	0			73	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	75	0			75	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	153	0			153	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,357	0			3,357	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	20,430	0			20,430	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	20,430	0			20,430	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	16.43	0.00			16.43	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011		Period: From 04/01/2015 To 03/31/2016		Worksheet DSH Date/Time Prepared: 8/29/2016 11:28 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	9.11		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00
30.00	Line 28 or 29 as applicable		9.11		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		9.11		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	True				True	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet DSH Date/Time Prepared: 8/29/2016 11:28 am
		Title VIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	3.43		29.00
30.00	Line 28 or 29 as applicable	3.43		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part B Date/Time Prepared: 8/29/2016 11:28 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		9,124	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		11,940,885	2.00
3.00	PPS payments		10,438,400	3.00
4.00	Outlier payment (see instructions)		27,813	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.804	5.00
6.00	Line 2 times line 5		9,600,472	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		9,124	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		39,773	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		39,773	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		39,773	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		30,649	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		9,124	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		10,466,213	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		140,647	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,225,809	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		8,108,881	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		8,108,881	30.00
31.00	Primary payer payments		547	31.00
32.00	Subtotal (line 30 minus line 31)		8,108,334	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		607,478	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		394,861	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		472,802	36.00
37.00	Subtotal (see instructions)		8,503,195	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,503,195	40.00
40.01	Sequestration adjustment (see instructions)		170,064	40.01
41.00	Interim payments		8,436,857	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-103,726	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
			Overrides	
			1.00	
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet E-1  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		25,204,871		8,376,798	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	03/24/2016	1,737,678	10/27/2015	38,941	3.01
3.02			0	03/24/2016	21,118	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	10/27/2015	122,293		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)		1,615,385		60,059	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		26,820,256		8,436,857	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1,063,109		103,726	6.02
7.00	Total Medicare program liability (see instructions)		25,757,147		8,333,131	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140011  
Component CCN: 14T011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet E-1  
Part I  
Date/Time Prepared:  
8/29/2016 11:28 am  
PPS

Title XVIII

Subprovider -  
IRF

		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					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		6,433,178		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)		6,433,178		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		11,935		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,445,113		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet E-1  
Part II  
Date/Time Prepared:  
8/29/2016 11:28 am

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		6,061	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		12,339	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		1,501	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		20,430	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		551,036,865	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		4,940,918	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		1,019,385	8.00
9.00	Sequestration adjustment amount (see instructions)		20,388	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		998,997	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		1,017,557	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		-18,560	32.00
				Overrides
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140011 Component CCN: 14T011	Period: From 04/01/2015 To 03/31/2016	Worksheet E-3 Part III Date/Time Prepared: 8/29/2016 11:28 am
		Title XVII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			5,924,316 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0523 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			327,615 3.00
4.00	Outlier Payments			380,751 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)			19.530055 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)			6,632,682 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)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			6,632,682 17.00
18.00	Primary payer payments			3,574 18.00
19.00	Subtotal (line 17 less line 18).			6,629,108 19.00
20.00	Deductibles			49,476 20.00
21.00	Subtotal (line 19 minus line 20)			6,579,632 21.00
22.00	Coinsurance			19,894 22.00
23.00	Subtotal (line 21 minus line 22)			6,559,738 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			26,013 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			16,908 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			15,547 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,576,646 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)			6,576,646 32.00
32.01	Sequestration adjustment (see instructions)			131,533 32.01
33.00	Interim payments			6,433,178 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)			11,935 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			380,751 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

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

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet G

Date/Time Prepared:  
8/29/2016 11:28 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	3,536,578	0	2,912	0	1.00
2.00	Temporary investments	15,082	0	0	0	2.00
3.00	Notes receivable	62,726	0	0	0	3.00
4.00	Accounts receivable	81,002,537	0	0	0	4.00
5.00	Other receivable	340,817	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-53,185,257	0	0	0	6.00
7.00	Inventory	2,122,859	0	0	0	7.00
8.00	Prepaid expenses	289,016	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	34,184,358	0	2,912	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,897,097	0	0	0	12.00
13.00	Land improvements	4,448,271	0	0	0	13.00
14.00	Accumulated depreciation	-2,654,756	0	0	0	14.00
15.00	Buildings	70,347,485	0	0	0	15.00
16.00	Accumulated depreciation	-37,196,963	0	0	0	16.00
17.00	Leasehold improvements	12,954	0	0	0	17.00
18.00	Accumulated depreciation	-3,245	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	332,971	0	0	0	21.00
22.00	Accumulated depreciation	-195,518	0	0	0	22.00
23.00	Major movable equipment	28,834,225	0	0	0	23.00
24.00	Accumulated depreciation	-17,678,341	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	8,174,731	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	58,318,911	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	999	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	2,368,345	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,369,344	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	94,872,613	0	2,912	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	5,217,299	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,198,236	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,373,920	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	5,540,628	0	0	0	43.00
44.00	Other current liabilities	1,685,612	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,015,695	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	39,675,380	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	7,160,987	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	46,836,367	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	65,852,062	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	29,020,551				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			2,912		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)	29,020,551	0	2,912	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	94,872,613	0	2,912	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet G-1

Date/Time Prepared:  
8/29/2016 11:28 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		116,865,971			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-87,845,415				2.00
3.00	Total (sum of line 1 and line 2)		29,020,556			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	RESTRICTED GRANTS	0		0		2,912	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)		29,020,556			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	5		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)		5			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,020,551			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	RESTRICTED GRANTS		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)	2,912		0			10.00
11.00	Subtotal (line 3 plus line 10)	2,912		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	ROUNDING		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	2,912		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
8/29/2016 11:28 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	19,734,203		19,734,203	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	12,240,707		12,240,707	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)	31,974,910		31,974,910	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,752,506		2,752,506	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,752,506		2,752,506	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	34,727,416		34,727,416	17.00
18.00	Ancillary services	178,742,140	345,120,061	523,862,201	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)	213,469,556	345,120,061	558,589,617	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		112,459,307		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		112,459,307		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140011

Period:  
From 04/01/2015  
To 03/31/2016

Worksheet G-3

Date/Time Prepared:  
8/29/2016 11:28 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	558,589,617	1.00
2.00	Less contractual allowances and discounts on patients' accounts	401,486,367	2.00
3.00	Net patient revenues (line 1 minus line 2)	157,103,250	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	112,459,307	4.00
5.00	Net income from service to patients (line 3 minus line 4)	44,643,943	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	31,578	6.00
7.00	Income from investments	134,781	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	3,910	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	523,641	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	1,262	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	72,199	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	321,763	22.00
23.00	Governmental appropriations	18,456	23.00
24.00	MISCELLANEOUS	3,869	24.00
25.00	Total other income (sum of lines 6-24)	1,111,459	25.00
26.00	Total (line 5 plus line 25)	45,755,402	26.00
27.00	CORP ALL/LOSS ON EQUIP/CONTR	133,600,817	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	133,600,817	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-87,845,415	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140011	Period: From 04/01/2015 To 03/31/2016	Worksheet L Parts I-III Date/Time Prepared: 8/29/2016 11:28 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,783,251	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		11,907	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		55.82	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,795,158	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00