

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: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/22/2016 12:55 pm
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Date: 11/22/2016 Time: 12:55 pm

Contractor use only

5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. 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 NORTHERN ILLINOIS MEDICAL CENTER (140116) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
 ECR: Date: 11/22/2016 Time: 12:55 pm
 oZxHzi WA0oxI Eo: 8uZSdyRoqFEJ 2I 0
 . Mm9b0E72w1LD2MYgc91kMNMQ0w4hc
 Ddl 71dqtlAOWTr2I
 PI: Date: 11/22/2016 Time: 12:55 pm
 uzwsdnukn: 2coDT98hfx6Fu1M9Kl m0
 w8bZJ08gaVBsyM8TzUn3dJ0GB0tzgG
 Lfym0xyXUL0ca6Xi

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	856,908	153,975	-32,425	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	36,562	29		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-1,894		0	9.00
200.00 Total	0	893,470	152,110	-32,425	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 12:45 pm			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4201 MEDICAL CENTER DRIVE			PO Box:				1.00				
2.00	City: MCHENRY		State: IL		Zip Code: 60050-		County: MCHENRY				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		NORTHERN ILLINOIS MEDICAL CENTER		140116	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		NIMC REHABILITATION UNIT		14T116	16974	5	07/01/1985	N	P	O	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		NIMC HOME HEALTH AGENCY		147455	16974		07/01/1986	N	P	N	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)						07/01/2015	06/30/2016		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) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						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 IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,219	873	0	3	4,510	206	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.			61	24	0	0	204		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 12:45 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			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		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.				N	81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.				N	87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			Y	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		
Rural Providers								
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00		
		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00		
					1.00	2.00	3.00	
Miscellaneous Cost Reporting Information								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0		
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00		
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	1,984,115		404,043		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		N		120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00		
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00		
Transplant Center Information								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 12:45 pm	
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H122			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: CENTEGRA HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131		141.00	
142.00	Street: 385 MILLENNIUM DR	PO Box:				142.00	
143.00	City: CRYSTAL LAKE	State: IL	Zip Code: 60012-3761				143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC	N	N	N	N	161.00	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		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	
168.01	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 12:45 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		04/01/2015	06/30/2015	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: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 12:45 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/27/2016	Y	10/27/2016
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: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 12:45 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		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		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		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		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANNA	BURACKER		41.00
42.00	Enter the employer/company name of the cost report preparer.	CENTEGRA HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(815)759-8037	ABURACKER@CENTEGRA.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-2
Part II
Date/Time Prepared:
11/22/2016 12:45 pm

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

VOLUNTARY CONTACT INFORMATION	Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part V Date/Time Prepared: 11/22/2016 12:45 pm
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		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	ANNA	1.00
2.00	Last Name	BURACKER	2.00
3.00	Title	SR. REIMBURSEMENT ANALYST	3.00
4.00	Employer	CENTEGRA HEALTH SYSTEM	4.00
5.00	Phone Number	(815)759-8037	5.00
6.00	E-mail Address	ABURACKER@CENTEGRA.COM	6.00
7.00	Department	FINANCE	7.00
8.00	Mailing Address 1	527 W. SOUTH ST.	8.00
9.00	Mailing Address 2		9.00
10.00	City	WOODSTOCK	10.00
11.00	State	IL	11.00
12.00	Zip	60098	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	DAVID	13.00
14.00	Last Name	TOMLINSON	14.00
15.00	Title	EXECUTIVE VP & CFO	15.00
16.00	Employer	CENTEGRA HEALTH SYSTEM	16.00
17.00	Phone Number	(815)788-5800	17.00
18.00	E-mail Address	DTOMLINSON@CENTEGRA.COM	18.00
19.00	Department	ADMINISTRATION	19.00
20.00	Mailing Address 1	385 MILLENNIUM DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	CRYSTAL LAKE	22.00
23.00	State	IL	23.00
24.00	Zip	60012	24.00

HFS Supplemental Information		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part IX Date/Time Prepared: 11/22/2016 12:45 pm
		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
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	
CRITICAL ACCESS HOSPITALS				
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	
RCE DISALLOWANCE				
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
PASS THROUGH COST				
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
RHC				
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: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2016 12:45 pm

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	133	48,678	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)		133	48,678	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	18	6,588	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		151	55,266	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	22	8,052		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	101.00				0	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)		173				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)		6	2,196			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: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2016 12:45 pm

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)	15,808	769	30,885			1.00
2.00 HMO and other (see instructions)	2,257	4,220				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	33	250				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)	15,808	769	30,885			7.00
8.00 INTENSIVE CARE UNIT	2,301	114	4,294			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		1,838	3,777			13.00
14.00 Total (see instructions)	18,109	2,721	38,956	0.00	1,128.56	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	4,802	61	6,668	0.00	35.75	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	19,519	1,670	29,593	0.00	34.16	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	1,198.47	27.00
28.00 Observation Bed Days		98	4,180			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	26	539			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: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2016 12:45 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,159	201	9,325	1.00
2.00 HMO and other (see instructions)			437	1,288		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				27		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	4,159	201	9,325	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	355	2	511	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	0.00					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: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part II Date/Time Prepared: 11/22/2016 12:45 pm
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	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	101,322,222	-19,063,884	82,258,338	2,492,814.00	33.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,354,184	377,098	5,731,282	166,831.00	34.35
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		19,721,125	0	19,721,125	662,170.00	29.78
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		650,514	0	650,514	3,155.00	206.19
14.00	Home office salaries & wage-related costs		30,870,785	0	30,870,785	526,095.00	58.68
15.00	Home office: Physician Part A - Administrative		36,953	0	36,953	405.00	91.24
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		20,461,626	0	20,461,626		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,635,401	0	1,635,401		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,175,823	-1,063,178	112,645	3,632.00	31.01
27.00	Administrative & General	5.00	23,971,756	-21,071,593	2,900,163	125,627.00	23.09
28.00	Administrative & General under contract (see inst.)		3,224,942	0	3,224,942	82,083.00	39.29
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	1,507,525	16,595	1,524,120	63,672.00	23.94
31.00	Laundry & Linen Service	8.00	39,239	464	39,703	2,143.00	18.53
32.00	Housekeeping	9.00	1,679,204	21,276	1,700,480	105,552.00	16.11
33.00	Housekeeping under contract (see instructions)		186,200	0	186,200	6,070.00	30.68
34.00	Dietary	10.00	1,610,011	-805,601	804,410	45,867.00	17.54
35.00	Dietary under contract (see instructions)		385,845	0	385,845	14,705.00	26.24
36.00	Cafeteria	11.00	0	826,363	826,363	39,658.00	20.84
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	2,274,021	11,890	2,285,911	55,104.00	41.48
39.00	Central Services and Supply	14.00	751,439	9,067	760,506	37,364.00	20.35
40.00	Pharmacy	15.00	3,714,369	49,736	3,764,105	89,643.00	41.99

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part II
Date/Time Prepared:
11/22/2016 12:45 pm

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part III
Date/Time Prepared:
11/22/2016 12:45 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	105,119,209	-19,063,884	86,055,325	2,595,672.00	33.15	1.00
2.00	Excluded area salaries (see instructions)	5,354,184	377,098	5,731,282	166,831.00	34.35	2.00
3.00	Subtotal salaries (line 1 minus line 2)	99,765,025	-19,440,982	80,324,043	2,428,841.00	33.07	3.00
4.00	Subtotal other wages & related costs (see inst.)	51,279,377	0	51,279,377	1,191,825.00	43.03	4.00
5.00	Subtotal wage-related costs (see inst.)	20,461,626	0	20,461,626	0.00	25.47	5.00
6.00	Total (sum of lines 3 thru 5)	171,506,028	-19,440,982	152,065,046	3,620,666.00	42.00	6.00
7.00	Total overhead cost (see instructions)	40,520,374	-22,004,981	18,515,393	671,120.00	27.59	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 11/22/2016 12:45 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,753,375	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		33,248	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		11,536,723	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		437,457	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		173,990	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)		861,194	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		827,311	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		5,707,505	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		9,370	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		421,728	22.00
23.00	Tuition Reimbursement		335,126	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		22,097,027	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet S-3
Part V
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	19,721,125	0	1.00
2.00	Hospital	19,721,125	0	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	0	0	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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140116 Component CCN: 147455		Period: From 07/01/2015 To 06/30/2016		Worksheet S-4 Date/Time Prepared: 11/22/2016 12:45 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	2,623	9	218	2,850 1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	1,234.00	127.00	567.00	1,928.00 2.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		11.89	0.00	11.89 3.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00 4.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00 5.00	
6.00	Direct Nursing Service			16.32	0.00	16.32 6.00	
7.00	Nursing Supervisor			0.00	0.00	0.00 7.00	
8.00	Physical Therapy Service			7.57	0.00	7.57 8.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00	
10.00	Occupational Therapy Service			0.90	0.00	0.90 10.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00	
12.00	Speech Pathology Service			0.46	0.00	0.46 12.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00 13.00	
14.00	Medical Social Service			0.60	0.00	0.60 14.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00 15.00	
16.00	Home Health Aide			2.78	0.00	2.78 16.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00 17.00	
18.00	Other (specify)			0.00	0.00	0.00 18.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2		19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974		20.00	
20.01				29404		20.01	
				Full Episodes			
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	8,399	772	250	140	9,561 21.00	
22.00	Skilled Nursing Visit Charges	1,712,390	154,600	53,290	28,560	1,948,840 22.00	
23.00	Physical Therapy Visits	6,582	72	122	45	6,821 23.00	
24.00	Physical Therapy Visit Charges	1,352,130	14,760	25,400	9,260	1,401,550 24.00	
25.00	Occupational Therapy Visits	776	40	2	9	827 25.00	
26.00	Occupational Therapy Visit Charges	156,005	8,200	410	1,845	166,460 26.00	
27.00	Speech Pathology Visits	436	24	7	3	470 27.00	
28.00	Speech Pathology Visit Charges	89,380	4,920	1,435	615	96,350 28.00	
29.00	Medical Social Service Visits	51	5	1	2	59 29.00	
30.00	Medical Social Service Visit Charges	12,630	1,190	250	500	14,570 30.00	
31.00	Home Health Aide Visits	1,586	186	3	6	1,781 31.00	
32.00	Home Health Aide Visit Charges	174,460	20,460	330	660	195,910 32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	17,830	1,099	385	205	19,519 33.00	
34.00	Other Charges	0	0	0	0	0 34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,496,995	204,130	81,115	41,440	3,823,680 35.00	
36.00	Total Number of Episodes (standard/non outlier)	1,191		133	15	1,339 36.00	
37.00	Total Number of Outlier Episodes		22		2	24 37.00	
38.00	Total Non-Routine Medical Supply Charges	207,810	30,661	4,507	4,926	247,904 38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/22/2016 12:45 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.278522	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		15,135,645	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		35,454	5.00	
6.00	Medicaid charges		116,090,456	6.00	
7.00	Medicaid cost (line 1 times line 6)		32,333,746	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)		17,162,647	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		17,162,647	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	6,628,798	1,483,665	8,112,463	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,846,266	413,233	2,259,499	21.00
22.00	Partial payment by patients approved for charity care	176,516	127,497	304,013	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,669,750	285,736	1,955,486	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		10,958,037	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		864,687	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		10,093,350	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,811,220	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,766,706	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		21,929,353	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A

Date/Time Prepared:
11/22/2016 12:45 pm

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	
GENERAL SERVICE COST CENTERS							
1.00	00100		9,709,945	9,709,945	-2,474,560	7,235,385	1.00
2.00	00200		0	0	6,604,439	6,604,439	2.00
4.00	00400	1,175,823	20,834,946	22,010,769	-553,185	21,457,584	4.00
5.00	00500	23,971,756	48,028,002	71,999,758	-2,902,197	69,097,561	5.00
7.00	00700	1,507,525	2,692,788	4,200,313	16,531	4,216,844	7.00
8.00	00800	39,239	814,526	853,765	464	854,229	8.00
9.00	00900	1,679,204	1,129,762	2,808,966	21,164	2,830,130	9.00
10.00	01000	1,610,011	2,003,281	3,613,292	-1,541,406	2,071,886	10.00
11.00	01100	0	0	0	1,562,144	1,562,144	11.00
13.00	01300	2,274,021	303,212	2,577,233	-168,644	2,408,589	13.00
14.00	01400	751,439	1,958,306	2,709,745	-1,685	2,708,060	14.00
15.00	01500	3,714,369	17,178,155	20,892,524	-16,086,632	4,805,892	15.00
16.00	01600	0	13,566	13,566	0	13,566	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,653,164	4,524,256	24,177,420	-3,898,595	20,278,825	30.00
31.00	03100	3,858,350	830,386	4,688,736	150,707	4,839,443	31.00
41.00	04100	2,410,392	130,052	2,540,444	325,370	2,865,814	41.00
43.00	04300	0	0	0	1,799,732	1,799,732	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,045,880	16,487,096	23,532,976	-11,689,205	11,843,771	50.00
51.00	05100	1,145,998	118,786	1,264,784	-5,953	1,258,831	51.00
52.00	05200	0	0	0	3,777,123	3,777,123	52.00
53.00	05300	42,231	524,255	566,486	-18,299	548,187	53.00
54.00	05400	5,514,533	3,949,109	9,463,642	6,536	9,470,178	54.00
55.00	05500	1,944,096	738,418	2,682,514	27,588	2,710,102	55.00
56.00	05600	516,655	741,363	1,258,018	7,620	1,265,638	56.00
57.00	05700	795,931	364,171	1,160,102	-32,623	1,127,479	57.00
58.00	05800	356,755	244,344	601,099	5,055	606,154	58.00
59.00	05900	1,321,107	6,135,860	7,456,967	-5,342,818	2,114,149	59.00
60.00	06000	16,613	10,639,791	10,656,404	-84,316	10,572,088	60.00
65.00	06500	1,280,232	394,992	1,675,224	-49,194	1,626,030	65.00
66.00	06600	7,730,516	2,102,312	9,832,828	85,365	9,918,193	66.00
67.00	06700	1,115,703	85,574	1,201,277	10,546	1,211,823	67.00
68.00	06800	543,500	12,037	555,537	7,042	562,579	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	30,882	5,124	36,006	1,326	37,332	70.01
71.00	07100	0	0	0	6,820,079	6,820,079	71.00
72.00	07200	0	0	0	12,043,935	12,043,935	72.00
73.00	07300	0	0	0	15,986,220	15,986,220	73.00
76.00	03140	449,643	38,547	488,190	2,702	490,892	76.00
76.97	07697	489,072	213,871	702,943	7,496	710,439	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	390,318	25,647,388	26,037,706	-144,514	25,893,192	90.00
90.01	09001	188,825	29,815	218,640	-395	218,245	90.01
91.00	09100	4,404,250	1,417,956	5,822,206	-13,446	5,808,760	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	410,397	868,263	1,278,660	-496,720	781,940	97.00
101.00	10100	2,943,792	457,421	3,401,213	45,203	3,446,416	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		3,809,207	3,809,207	-3,809,207	0	113.00
118.00		101,322,222	185,176,883	286,499,105	793	286,499,898	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	6	6	0	6	190.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	7,952	7,952	-793	7,159	192.02
192.04	19204	0	0	0	0	0	192.04
200.00		101,322,222	185,184,841	286,507,063	0	286,507,063	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,800,477	3,434,908	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	6,604,439	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-390	21,457,194	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-24,597,828	44,499,733	5.00
7.00	00700	OPERATION OF PLANT	-469,799	3,747,045	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	854,229	8.00
9.00	00900	HOUSEKEEPING	-171,300	2,658,830	9.00
10.00	01000	DIETARY	0	2,071,886	10.00
11.00	01100	CAFETERIA	-901,404	660,740	11.00
13.00	01300	NURSING ADMINISTRATION	905,397	3,313,986	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,708,060	14.00
15.00	01500	PHARMACY	-2,422,652	2,383,240	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,876,912	3,890,478	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,067,783	18,211,042	30.00
31.00	03100	INTENSIVE CARE UNIT	-15,500	4,823,943	31.00
41.00	04100	SUBPROVIDER - I RF	0	2,865,814	41.00
43.00	04300	NURSERY	0	1,799,732	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-724,163	11,119,608	50.00
51.00	05100	RECOVERY ROOM	0	1,258,831	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,777,123	52.00
53.00	05300	ANESTHESIOLOGY	-12,926	535,261	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-365,118	9,105,060	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-27,890	2,682,212	55.00
56.00	05600	RADIOISOTOPE	0	1,265,638	56.00
57.00	05700	CT SCAN	0	1,127,479	57.00
58.00	05800	MRI	0	606,154	58.00
59.00	05900	CARDIAC CATHETERIZATION	-5,625	2,108,524	59.00
60.00	06000	LABORATORY	-659,839	9,912,249	60.00
65.00	06500	RESPIRATORY THERAPY	-52,272	1,573,758	65.00
66.00	06600	PHYSICAL THERAPY	-461,365	9,456,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	-21,101	1,190,722	67.00
68.00	06800	SPEECH PATHOLOGY	0	562,579	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	37,332	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,820,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,043,935	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,986,220	73.00
76.00	03140	CARDIOLOGY	0	490,892	76.00
76.97	07697	CARDIAC REHABILITATION	-58,065	652,374	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-1,281,974	24,611,218	90.00
90.01	09001	DIABETES CENTER	-238	218,007	90.01
91.00	09100	EMERGENCY	26,064	5,834,824	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	-660	781,280	97.00
101.00	10100	HOME HEALTH AGENCY	-28,894	3,417,522	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-33,338,890	253,161,008	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6	190.00
192.01	19201	OCCUPATIONAL HEALTH	0	0	192.01
192.02	19202	FLIGHT FOR LIFE	0	7,159	192.02
192.04	19204	WELLNESS PROGRAM	0	0	192.04
200.00		TOTAL (SUM OF LINES 118-199)	-33,338,890	253,168,173	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet Non-CMS W
Date/Time Prepared: 11/22/2016 12:45 pm				
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
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
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
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
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00	RADIOLOGY-THERAPEUTIC	05500		55.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
70.01	SLEEP LAB/NEUROLOGY	07001		70.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	CARDIOLOGY	03140	CARDIOLOGY	76.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
90.01	DIABETES CENTER	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	DURABLE MEDICAL EQUIP-SOLD	09700		97.00
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.01	OCCUPATIONAL HEALTH	19201		192.01
192.02	FLIGHT FOR LIFE	19202		192.02
192.04	WELLNESS PROGRAM	19204		192.04
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6

Date/Time Prepared:
11/22/2016 12:45 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAPITAL RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,422,560	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	36,996	2.00
	TOTALS		0	6,459,556	
B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	826,363	735,781	1.00
	TOTALS		826,363	735,781	
C - MED SUPPLIES & IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,820,079	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,043,935	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	O		0	18,864,014	
D - NURSERY					
1.00	NURSERY	43.00	1,031,179	594,660	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,395,619	1,381,504	2.00
	TOTALS		3,426,798	1,976,164	
E - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,984,996	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	181,879	2.00
	O		0	4,166,875	
F - CHARGABLE DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,986,220	1.00
	TOTALS		0	15,986,220	
G - ATO RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	63,092	0	1.00
2.00	OPERATION OF PLANT	7.00	16,595	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	464	0	3.00
4.00	HOUSEKEEPING	9.00	21,276	0	4.00
5.00	DIETARY	10.00	20,762	0	5.00
6.00	NURSING ADMINISTRATION	13.00	11,890	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	9,067	0	7.00
8.00	PHARMACY	15.00	49,736	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	253,530	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	52,187	0	10.00
11.00	SUBPROVIDER - IRF	41.00	32,779	0	11.00
12.00	OPERATING ROOM	50.00	103,917	0	12.00
13.00	RECOVERY ROOM	51.00	16,648	0	13.00
14.00	ANESTHESIOLOGY	53.00	716	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	67,744	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	32,983	0	16.00
17.00	RADIOISOTOPE	56.00	8,218	0	17.00
18.00	CT SCAN	57.00	10,590	0	18.00
19.00	MRI	58.00	6,269	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	15,409	0	20.00

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6

Date/Time Prepared:
11/22/2016 12:45 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
21.00	RESPIRATORY THERAPY	65.00	15,684	0	21.00
22.00	PHYSICAL THERAPY	66.00	107,282	0	22.00
23.00	OCCUPATIONAL THERAPY	67.00	12,282	0	23.00
24.00	SPEECH PATHOLOGY	68.00	7,215	0	24.00
25.00	SLEEP LAB/NEUROLOGY	70.01	1,326	0	25.00
26.00	CARDIOLOGY	76.00	6,448	0	26.00
27.00	CARDIAC REHABILITATION	76.97	8,745	0	27.00
28.00	CLINIC	90.00	7,353	0	28.00
29.00	DIABETES CENTER	90.01	1,094	0	29.00
30.00	EMERGENCY	91.00	49,739	0	30.00
31.00	DURABLE MEDICAL EQUIP-SOLD	97.00	6,935	0	31.00
32.00	HOME HEALTH AGENCY	101.00	45,203	0	32.00
			1,063,178	0	
H - CENTEGRA ALLOCATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,061,935	1.00
	TOTALS		0	19,061,935	
I - CASE MANAGEMENT/SOCIAL SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	1,409,632	37,122	1.00
2.00	INTENSIVE CARE UNIT	31.00	192,622	5,073	2.00
3.00	SUBPROVIDER - IRF	41.00	299,116	7,877	3.00
4.00	NURSERY	43.00	169,431	4,462	4.00
			2,070,801	54,534	
J - WORKERS COMP INSURANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	509,993	1.00
	TOTALS		0	509,993	
K - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,949	1.00
			0	1,949	
500.00	Grand Total: Increases		7,387,140	67,817,021	500.00

RECLASSIFICATIONS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6

Date/Time Prepared:
11/22/2016 12:45 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - CAPITAL RECLASS							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,459,556	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	6,459,556			
B - CAFETERIA RECLASS							
1.00	DIETARY	10.00	826,363	735,781	0		1.00
	TOTALS		826,363	735,781			
C - MED SUPPLIES & IMPLANTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,289	0		1.00
2.00	OPERATION OF PLANT	7.00	0	64	0		2.00
3.00	HOUSEKEEPING	9.00	0	112	0		3.00
4.00	DIETARY	10.00	0	24	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	180,534	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,752	0		6.00
7.00	PHARMACY	15.00	0	150,148	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	195,917	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	99,175	0		9.00
10.00	SUBPROVIDER - IRF	41.00	0	14,402	0		10.00
11.00	OPERATING ROOM	50.00	0	11,793,122	0		11.00
12.00	RECOVERY ROOM	51.00	0	22,601	0		12.00
13.00	ANESTHESIOLOGY	53.00	0	19,015	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	61,208	0		14.00
15.00	RADIOLOGY-THERAPEUTIC	55.00	0	5,395	0		15.00
16.00	RADIOISOTOPE	56.00	0	598	0		16.00
17.00	CT SCAN	57.00	0	43,213	0		17.00
18.00	MRI	58.00	0	1,214	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	5,358,227	0		19.00
20.00	LABORATORY	60.00	0	84,316	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	64,878	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	21,917	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	1,736	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	173	0		24.00
25.00	CARDIOLOGY	76.00	0	3,746	0		25.00
26.00	CARDIAC REHABILITATION	76.97	0	1,249	0		26.00
27.00	CLINIC	90.00	0	151,867	0		27.00
28.00	DIABETES CENTER	90.01	0	1,489	0		28.00
29.00	EMERGENCY	91.00	0	63,185	0		29.00
30.00	DURABLE MEDICAL EQUIP-SOLD	97.00	0	503,655	0		30.00
31.00	FLIGHT FOR LIFE	192.02	0	793	0		31.00
	O		0	18,864,014			
D - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	3,426,798	1,976,164	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		3,426,798	1,976,164			
E - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	357,668	11		1.00
2.00	INTEREST EXPENSE	113.00	0	3,809,207	11		2.00
	O		0	4,166,875			
F - CHARGABLE DRUG COSTS							
1.00	PHARMACY	15.00	0	15,986,220	0		1.00
	TOTALS		0	15,986,220			
G - ATO RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,063,178	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6

Date/Time Prepared:
11/22/2016 12:45 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
23.00	0.00	0	0	0	0		23.00
24.00	0.00	0	0	0	0		24.00
25.00	0.00	0	0	0	0		25.00
26.00	0.00	0	0	0	0		26.00
27.00	0.00	0	0	0	0		27.00
28.00	0.00	0	0	0	0		28.00
29.00	0.00	0	0	0	0		29.00
30.00	0.00	0	0	0	0		30.00
31.00	0.00	0	0	0	0		31.00
32.00	0.00	0	0	0	0		32.00
0		1,063,178		0			
H - CENTEGRA ALLOCATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	19,061,935	0	0		1.00
	TOTALS		19,061,935	0			
I - CASE MANAGEMENT/SOCIAL SERVICES							
1.00	ADMINISTRATIVE & GENERAL	5.00	2,070,801	54,534	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
0			2,070,801	54,534			
J - WORKERS COMP INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	509,993	0		1.00
	TOTALS		0	509,993			
K - SALARY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	1,949	0	0		1.00
0			1,949	0			
500.00	Grand Total: Decreases		26,451,024	48,753,137			500.00

RECLASSIFICATIONS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
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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		
A - CAPITAL RECLASS									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,422,560	CAP REL COSTS-BLDG & FIXT	1.00	0	6,459,556	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	36,996		0.00	0	0	2.00
	TOTALS		0	6,459,556	TOTALS		0	6,459,556	
B - CAFETERIA RECLASS									
1.00	CAFETERIA	11.00	826,363	735,781	DIETARY	10.00	826,363	735,781	1.00
	TOTALS		826,363	735,781	TOTALS		826,363	735,781	
C - MED SUPPLIES & IMPLANTS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,820,079	ADMINISTRATIVE & GENERAL	5.00	0	9,289	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,043,935	OPERATION OF PLANT	7.00	0	64	2.00
3.00		0.00	0	0	HOUSEKEEPING	9.00	0	112	3.00
4.00		0.00	0	0	DIETARY	10.00	0	24	4.00
5.00		0.00	0	0	NURSING	13.00	0	180,534	5.00
6.00		0.00	0	0	ADMINISTRATION				
7.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	10,752	6.00
8.00		0.00	0	0	PHARMACY	15.00	0	150,148	7.00
9.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	195,917	8.00
10.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	99,175	9.00
11.00		0.00	0	0	SUBPROVIDER - IIRF	41.00	0	14,402	10.00
12.00		0.00	0	0	OPERATING ROOM	50.00	0	11,793,122	11.00
13.00		0.00	0	0	RECOVERY ROOM	51.00	0	22,601	12.00
14.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	19,015	13.00
15.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	61,208	14.00
16.00		0.00	0	0	RADIOLOGY-THERAPEUTIC	55.00	0	5,395	15.00
17.00		0.00	0	0	RADIOISOTOPE	56.00	0	598	16.00
18.00		0.00	0	0	CT SCAN	57.00	0	43,213	17.00
19.00		0.00	0	0	MRI	58.00	0	1,214	18.00
20.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	5,358,227	19.00
21.00		0.00	0	0	LABORATORY	60.00	0	84,316	20.00
22.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	64,878	21.00
23.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	21,917	22.00
24.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	1,736	23.00
25.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	173	24.00
26.00		0.00	0	0	CARDIOLOGY	76.00	0	3,746	25.00
27.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	1,249	26.00
28.00		0.00	0	0	CLINIC	90.00	0	151,867	27.00
29.00		0.00	0	0	DIABETES CENTER	90.01	0	1,489	28.00
30.00		0.00	0	0	EMERGENCY	91.00	0	63,185	29.00
31.00		0.00	0	0	DURABLE MEDICAL EQUIP-SOLD	97.00	0	503,655	30.00
		0.00	0	0	FLIGHT FOR LIFE	192.02	0	793	31.00
0			0	18,864,014	0		0	18,864,014	
D - NURSERY									
1.00	NURSERY	43.00	1,031,179	594,660	ADULTS & PEDIATRICS	30.00	3,426,798	1,976,164	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,395,619	1,381,504		0.00	0	0	2.00
	TOTALS		3,426,798	1,976,164	TOTALS		3,426,798	1,976,164	
E - INTEREST EXPENSE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,984,996	ADMINISTRATIVE & GENERAL	5.00	0	357,668	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	181,879	INTEREST EXPENSE	113.00	0	3,809,207	2.00
	0		0	4,166,875	0		0	4,166,875	
F - CHARGABLE DRUG COSTS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,986,220	PHARMACY	15.00	0	15,986,220	1.00
	TOTALS		0	15,986,220	TOTALS		0	15,986,220	
G - ATO RECLASS									
1.00	ADMINISTRATIVE & GENERAL	5.00	63,092	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,063,178	0	1.00
2.00	OPERATION OF PLANT	7.00	16,595	0		0.00	0	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	464	0		0.00	0	0	3.00
4.00	HOUSEKEEPING	9.00	21,276	0		0.00	0	0	4.00
5.00	DIETARY	10.00	20,762	0		0.00	0	0	5.00
6.00	NURSING	13.00	11,890	0		0.00	0	0	6.00
	ADMINISTRATION								

RECLASSIFICATIONS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
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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	
7.00	CENTRAL SERVICES & SUPPLY	14.00	9,067	0		0.00	0	0	7.00
8.00	PHARMACY	15.00	49,736	0		0.00	0	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	253,530	0		0.00	0	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	52,187	0		0.00	0	0	10.00
11.00	SUBPROVIDER - IRF	41.00	32,779	0		0.00	0	0	11.00
12.00	OPERATING ROOM	50.00	103,917	0		0.00	0	0	12.00
13.00	RECOVERY ROOM	51.00	16,648	0		0.00	0	0	13.00
14.00	ANESTHESIOLOGY	53.00	716	0		0.00	0	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	67,744	0		0.00	0	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	32,983	0		0.00	0	0	16.00
17.00	RADIOISOTOPE	56.00	8,218	0		0.00	0	0	17.00
18.00	CT SCAN	57.00	10,590	0		0.00	0	0	18.00
19.00	MRI	58.00	6,269	0		0.00	0	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	15,409	0		0.00	0	0	20.00
21.00	RESPIRATORY THERAPY	65.00	15,684	0		0.00	0	0	21.00
22.00	PHYSICAL THERAPY	66.00	107,282	0		0.00	0	0	22.00
23.00	OCCUPATIONAL THERAPY	67.00	12,282	0		0.00	0	0	23.00
24.00	SPEECH PATHOLOGY	68.00	7,215	0		0.00	0	0	24.00
25.00	SLEEP LAB/NEUROLOGY	70.01	1,326	0		0.00	0	0	25.00
26.00	CARDIOLOGY	76.00	6,448	0		0.00	0	0	26.00
27.00	CARDIAC REHABILITATION	76.97	8,745	0		0.00	0	0	27.00
28.00	CLINIC	90.00	7,353	0		0.00	0	0	28.00
29.00	DIABETES CENTER	90.01	1,094	0		0.00	0	0	29.00
30.00	EMERGENCY	91.00	49,739	0		0.00	0	0	30.00
31.00	DURABLE MEDICAL EQUIP-SOLD	97.00	6,935	0		0.00	0	0	31.00
32.00	HOME HEALTH AGENCY	101.00	45,203	0		0.00	0	0	32.00
			1,063,178	0			1,063,178	0	
H - CENTEGRA ALLOCATION									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,061,935	ADMINISTRATIVE & GENERAL	5.00	19,061,935	0	1.00
	TOTALS		0	19,061,935	TOTALS		19,061,935	0	
I - CASE MANAGEMENT/SOCIAL SERVICES									
1.00	ADULTS & PEDIATRICS	30.00	1,409,632	37,122	ADMINISTRATIVE & GENERAL	5.00	2,070,801	54,534	1.00
2.00	INTENSIVE CARE UNIT	31.00	192,622	5,073		0.00	0	0	2.00
3.00	SUBPROVIDER - IRF	41.00	299,116	7,877		0.00	0	0	3.00
4.00	NURSERY	43.00	169,431	4,462		0.00	0	0	4.00
			2,070,801	54,534			2,070,801	54,534	
J - WORKERS COMP INSURANCE									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	509,993	ADMINISTRATIVE & GENERAL	5.00	0	509,993	1.00
	TOTALS		0	509,993	TOTALS		0	509,993	
K - SALARY RECLASS									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,949	ADMINISTRATIVE & GENERAL	5.00	1,949	0	1.00
			0	1,949			1,949	0	
500.00	Grand Total: Increases		7,387,140	67,817,021	Grand Total: Decreases		26,451,024	48,753,137	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

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		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,000	0	0	0	0	1.00
2.00	Land Improvements	1,764,249	0	0	0	0	2.00
3.00	Buildings and Fixtures	83,339,494	173,416,094	0	173,416,094	0	3.00
4.00	Building Improvements	77,154	474,098	0	474,098	0	4.00
5.00	Fixed Equipment	12,588,902	0	0	0	0	5.00
6.00	Movable Equipment	102,677,067	22,060,547	0	22,060,547	0	6.00
7.00	HIT designated Assets	9,071,668	264,983	0	264,983	0	7.00
8.00	Subtotal (sum of lines 1-7)	209,583,534	196,215,722	0	196,215,722	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	209,583,534	196,215,722	0	196,215,722	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,000	0				1.00
2.00	Land Improvements	1,764,249	0				2.00
3.00	Buildings and Fixtures	256,755,588	0				3.00
4.00	Building Improvements	551,252	0				4.00
5.00	Fixed Equipment	12,588,902	0				5.00
6.00	Movable Equipment	124,737,614	0				6.00
7.00	HIT designated Assets	9,336,651	0				7.00
8.00	Subtotal (sum of lines 1-7)	405,799,256	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	405,799,256	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part II
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	9,709,945	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,709,945	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	9,709,945				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	9,709,945				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-7
Part III
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	259,136,089	0	259,136,089	0.638582	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	146,663,167	0	146,663,167	0.361418	0	2.00
3.00	Total (sum of lines 1-2)	405,799,256	0	405,799,256	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	3,250,389	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,422,560	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,672,949	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	184,519	0	0	0	3,434,908	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	181,879	0	0	0	6,604,439	2.00
3.00	Total (sum of lines 1-2)	366,398	0	0	0	10,039,347	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8

Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,140,154	CAP REL COSTS-BLDG & FIXT		1.00	11 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)	A	-148,883	OPERATION OF PLANT		7.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-252,106	OPERATION OF PLANT		7.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-3,950,639				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	-10,683,677				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-895,608	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	-3,574	MEDICAL RECORDS & LIBRARY		16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 MEDICAL STAFF FEES	B	-15,761	ADMINISTRATIVE & GENERAL		5.00	0 33.00
34.00 OTHER INCOME	B	-419,309	ADMINISTRATIVE & GENERAL		5.00	0 34.00

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	3.00	
35.00 RADIOLOGY X-RAY COPY FEES	B	15	RADIOLOGY-DIAGNOSTIC		54.00	0 35.00
36.00 COPYING FEES PATIENT ACCTS	B	-1,175	ADMINISTRATIVE & GENERAL		5.00	0 36.00
37.00 NURSING EDUCATION INCOME	B	-4,865	NURSING ADMINISTRATION		13.00	0 37.00
38.00 OB EDUCATION INCOME	B	-27,302	ADULTS & PEDIATRICS		30.00	0 38.00
39.00 RADIOLOGY OTHER INCOME	B	-47,880	RADIOLOGY-DIAGNOSTIC		54.00	0 39.00
40.00 EDUCATION INCOME	B	-5,177	EMERGENCY		91.00	0 40.00
41.00 EMS TUITION INCOME	B	-78,678	EMERGENCY		91.00	0 41.00
42.00 ONCOLOGY EDUCATION INCOME	B	-3,266	RADIOLOGY-THERAPEUTIC		55.00	0 42.00
43.00 PT OTHER INCOME	B	-158,580	PHYSICAL THERAPY		66.00	0 43.00
44.00 LABORATORY INCOME	B	-87,066	LABORATORY		60.00	0 44.00
45.00 MAINTENANCE SERVICES	B	-53,363	OPERATION OF PLANT		7.00	0 45.00
45.01 HOUSEKEEPING SERVICES	B	-171,300	HOUSEKEEPING		9.00	0 45.01
45.02 PHARMACY RETAIL INCOME	B	-2,421,336	PHARMACY		15.00	0 45.02
45.03 CLINIC OTHER INCOME	B	-9,403	CLINIC		90.00	0 45.03
45.04 RELATED PARTY SALARIES	A	-1,949	ADMINISTRATIVE & GENERAL		5.00	0 45.04
45.05 RELATED PARTY BENEFITS	A	-390	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.05
45.06 MEALS ON WHEELS	B	-5,796	CAFETERIA		11.00	0 45.06
45.07 IDPA PROVIDER TAX	A	-7,419,667	ADMINISTRATIVE & GENERAL		5.00	0 45.07
45.08 CHILD CARE CENTER	B	-739,514	ADMINISTRATIVE & GENERAL		5.00	0 45.08
45.09 2012 & 2014 INTEREST INCOME	B	-54	CAP REL COSTS-BLDG & FIXT		1.00	11 45.09
45.10 2012 & 2014 INTEREST EXPENSE	A	-660,269	CAP REL COSTS-BLDG & FIXT		1.00	11 45.10
45.11 RELATED RENTAL - POM/BIOMED	A	-15,447	OPERATION OF PLANT		7.00	0 45.11
45.12 RELATED RENTAL - NURSING ADMIN	A	-8,028	NURSING ADMINISTRATION		13.00	0 45.12
45.13 RELATED RENTAL - ANIT-COAG	A	-1,316	PHARMACY		15.00	0 45.13
45.14 RELATED RENTAL - MEDICAL RECORDS	A	-4,270	MEDICAL RECORDS & LIBRARY		16.00	0 45.14
45.15 RELATED RENTAL - RADIOLOGY	A	-263,326	RADIOLOGY-DIAGNOSTIC		54.00	0 45.15
45.16 RELATED RENTAL - ONCOLOGY ADMIN	A	-9,235	RADIOLOGY-THERAPEUTIC		55.00	0 45.16
45.17 RELATED RENTAL - PHYSICAL THERAPY	A	-285,242	PHYSICAL THERAPY		66.00	0 45.17
45.18 RELATED RENTAL - OCCUPATIONAL THERAP	A	-21,101	OCCUPATIONAL THERAPY		67.00	0 45.18
45.19 RELATED RENTAL - CARDIAC REHAB	A	-58,311	CARDIAC REHABILITATION		76.97	0 45.19
45.20 RELATED RENTAL - VARIOUS CLINICS	A	-1,229,538	CLINIC		90.00	0 45.20
45.21 RELATED RENTAL - ER	A	-6,796	EMERGENCY		91.00	0 45.21
45.22 RELATED RENTAL - DME	A	-660	DURABLE MEDICAL EQUIP-SOLD		97.00	0 45.22
45.23 RELATED RENTAL - HOME HEALTH	A	-28,894	HOME HEALTH AGENCY		101.00	0 45.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-33,338,890				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: 140116

Period: From 07/01/2015 To 06/30/2016

Worksheet A-8-1

Date/Time Prepared: 11/22/2016 12:45 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CENTEGRA HEALTH SYSTEM	40,291,953	55,986,851 1.00
2.00	13.00	NURSING ADMINISTRATION	CENTEGRA HEALTH SYSTEM	918,290	0 2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	CENTEGRA HEALTH SYSTEM	3,884,756	0 3.00
4.00	91.00	EMERGENCY	CENTEGRA HEALTH SYSTEM	483,444	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	CENTEGRA INSURANCE SERVICES	1,708,846	1,984,115 4.01
5.00	0			47,287,289	57,970,966 5.00

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

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

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

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

6.00	B	0.00	CENTEGRA HEALTH	0.00	6.00
7.00	B	0.00	CENTEGRA INSURA	0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-1

Date/Time Prepared:
11/22/2016 12:45 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-15,694,898	0		1.00
2.00	918,290	0		2.00
3.00	3,884,756	0		3.00
4.00	483,444	0		4.00
4.01	-275,269	0		4.01
5.00	-10,683,677			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	INSURANCE SERVI		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-2

Date/Time Prepared:

11/22/2016 12:45 pm

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	90.00 DR. BL	40,625	3,125	37,500	246,400	122	1.00
2.00	31.00 INTENSIVE CARE UNIT	15,500	15,500	0	0	0	2.00
3.00	30.00 ADULTS & PEDIATRICS	1,897,600	1,897,600	0	0	0	3.00
4.00	30.00 DR. BA	91,875	0	91,875	246,400	255	4.00
5.00	30.00 DR. BB	91,875	12,500	79,375	246,400	90	5.00
6.00	50.00 OPERATING ROOM	724,163	724,163	0	0	0	6.00
7.00	53.00 ANESTHESIOLOGY	60,000	0	60,000	239,400	409	7.00
8.00	60.00 LABORATORY	572,773	572,773	0	0	0	8.00
9.00	54.00 DR. BC	24,000	0	24,000	271,900	111	9.00
10.00	54.00 DR. BD	7,200	0	7,200	271,900	327	10.00
11.00	54.00 DR. BE	20,000	0	20,000	271,900	126	11.00
12.00	54.00 DR. BF	168,000	0	168,000	271,900	960	12.00
13.00	54.00 RADIOLOGY-DIAGNOSTIC	-1,600	-1,600	0	0	0	13.00
14.00	59.00 CARDIAC CATHETERIZATION	10,608	0	10,608	211,500	49	14.00
15.00	65.00 RESPIRATORY THERAPY	52,272	52,272	0	0	0	15.00
16.00	66.00 PHYSICAL THERAPY	21,000	0	21,000	211,500	34	16.00
17.00	76.97 DR. BG	4,550	0	4,550	211,500	38	17.00
18.00	76.97 DR. BH	1,950	0	1,950	211,500	19	18.00
19.00	76.97 CARDIAC REHABILITATION	-950	-950	0	0	0	19.00
20.00	90.01 DIABETES CENTER	10,000	0	10,000	211,500	96	20.00
21.00	90.00 DR. BM	40,755	-3,705	44,460	211,500	235	21.00
22.00	55.00 RADIOLOGY-THERAPEUTIC	39,996	0	39,996	211,500	242	22.00
23.00	91.00 EMERGENCY	371,000	341,000	30,000	211,500	42	23.00
24.00	5.00 ADMINISTRATIVE & GENERAL	23,250	23,250	0	0	0	24.00
25.00	5.00 DR. BI	14,028	0	14,028	211,500	113	25.00
26.00	5.00 DR. BJ	16,800	0	16,800	211,500	276	26.00
27.00	5.00 DR. BK	6,125	0	6,125	211,500	16	27.00
200.00		4,323,395	3,635,928	687,467		3,560	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	90.00 DR. BL	14,452	723	0	0	0	1.00
2.00	31.00 INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	30.00 DR. BA	30,208	1,510	0	0	0	4.00
5.00	30.00 DR. BB	10,661	533	0	0	0	5.00
6.00	50.00 OPERATING ROOM	0	0	0	0	0	6.00
7.00	53.00 ANESTHESIOLOGY	47,074	2,354	0	0	0	7.00
8.00	60.00 LABORATORY	0	0	0	0	0	8.00
9.00	54.00 DR. BC	14,510	726	0	0	0	9.00
10.00	54.00 DR. BD	42,746	2,137	0	0	0	10.00
11.00	54.00 DR. BE	16,471	824	0	0	0	11.00
12.00	54.00 DR. BF	125,492	6,275	0	0	0	12.00
13.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	13.00
14.00	59.00 CARDIAC CATHETERIZATION	4,983	249	0	0	0	14.00
15.00	65.00 RESPIRATORY THERAPY	0	0	0	0	0	15.00
16.00	66.00 PHYSICAL THERAPY	3,457	173	0	0	0	16.00
17.00	76.97 DR. BG	3,864	193	0	0	0	17.00
18.00	76.97 DR. BH	1,932	97	0	0	0	18.00
19.00	76.97 CARDIAC REHABILITATION	0	0	0	0	0	19.00
20.00	90.01 DIABETES CENTER	9,762	488	0	0	0	20.00
21.00	90.00 DR. BM	23,895	1,195	0	0	0	21.00
22.00	55.00 RADIOLOGY-THERAPEUTIC	24,607	1,230	0	0	0	22.00
23.00	91.00 EMERGENCY	4,271	214	0	0	0	23.00
24.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	0	0	24.00
25.00	5.00 DR. BI	11,490	575	0	0	0	25.00
26.00	5.00 DR. BJ	28,064	1,403	0	0	0	26.00
27.00	5.00 DR. BK	1,627	81	0	0	0	27.00
200.00		419,566	20,980	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	90.00 DR. BL	0	14,452	23,048	26,173	1.00
2.00	31.00 INTENSIVE CARE UNIT	0	0	0	15,500	2.00
3.00	30.00 ADULTS & PEDIATRICS	0	0	0	1,897,600	3.00
4.00	30.00 DR. BA	0	30,208	61,667	61,667	4.00
5.00	30.00 DR. BB	0	10,661	68,714	81,214	5.00
6.00	50.00 OPERATING ROOM	0	0	0	724,163	6.00
7.00	53.00 ANESTHESIOLOGY	0	47,074	12,926	12,926	7.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet A-8-2

Date/Time Prepared:
11/22/2016 12:45 pm

	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		
8.00	60.00	LABORATORY	0	0	0	572,773		8.00
9.00	54.00	DR. BC	0	14,510	9,490	9,490		9.00
10.00	54.00	DR. BD	0	42,746	0	0		10.00
11.00	54.00	DR. BE	0	16,471	3,529	3,529		11.00
12.00	54.00	DR. BF	0	125,492	42,508	42,508		12.00
13.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	-1,600		13.00
14.00	59.00	CARDIAC CATHETERIZATION	0	4,983	5,625	5,625		14.00
15.00	65.00	RESPIRATORY THERAPY	0	0	0	52,272		15.00
16.00	66.00	PHYSICAL THERAPY	0	3,457	17,543	17,543		16.00
17.00	76.97	DR. BG	0	3,864	686	686		17.00
18.00	76.97	DR. BH	0	1,932	18	18		18.00
19.00	76.97	CARDIAC REHABILITATION	0	0	0	-950		19.00
20.00	90.01	DIABETES CENTER	0	9,762	238	238		20.00
21.00	90.00	DR. BM	0	23,895	20,565	16,860		21.00
22.00	55.00	RADIOLOGY-THERAPEUTIC	0	24,607	15,389	15,389		22.00
23.00	91.00	EMERGENCY	0	4,271	25,729	366,729		23.00
24.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	23,250		24.00
25.00	5.00	DR. BI	0	11,490	2,538	2,538		25.00
26.00	5.00	DR. BJ	0	28,064	0	0		26.00
27.00	5.00	DR. BK	0	1,627	4,498	4,498		27.00
200.00			0	419,566	314,711	3,950,639		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140116

Period: From 07/01/2015 To 06/30/2016

Worksheet B Part I Date/Time Prepared: 11/22/2016 12:45 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
		BLDG & FIXT	MVBLE EQUIP				
	0	1.00	2.00	4.00	4A		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	3,434,908	3,434,908				1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP	6,604,439		6,604,439			2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	21,457,194	3,067	5,898	21,466,159		4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	44,499,733	633,933	1,218,890	757,865	47,110,421	5.00	
7.00 00700 OPERATION OF PLANT	3,747,045	276,720	532,061	398,280	4,954,106	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	854,229	5,437	10,455	10,375	880,496	8.00	
9.00 00900 HOUSEKEEPING	2,658,830	38,992	74,971	444,366	3,217,159	9.00	
10.00 01000 DIETARY	2,071,886	101,291	194,756	210,207	2,578,140	10.00	
11.00 01100 CAFETERIA	660,740	0	0	215,944	876,684	11.00	
13.00 01300 NURSING ADMINISTRATION	3,313,986	17,579	33,800	597,350	3,962,715	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	2,708,060	65,052	125,079	198,734	3,096,925	14.00	
15.00 01500 PHARMACY	2,383,240	62,496	120,164	983,628	3,549,528	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	3,890,478	0	0	0	3,890,478	16.00	
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	18,211,042	738,688	1,420,303	4,674,866	25,044,899	30.00	
31.00 03100 INTENSIVE CARE UNIT	4,823,943	104,463	200,855	1,072,229	6,201,490	31.00	
41.00 04100 SUBPROVIDER - IRF	2,865,814	99,897	192,075	716,609	3,874,395	41.00	
43.00 04300 NURSERY	1,799,732	88,754	170,652	313,741	2,372,879	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	11,119,608	497,194	955,976	1,868,371	14,441,149	50.00	
51.00 05100 RECOVERY ROOM	1,258,831	27,164	52,230	303,820	1,642,045	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,777,123	48,659	93,558	626,018	4,545,358	52.00	
53.00 05300 ANESTHESIOLOGY	535,261	7,599	14,610	11,223	568,693	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,105,060	116,813	224,602	1,458,749	10,905,224	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	2,682,212	131,441	252,727	516,646	3,583,026	55.00	
56.00 05600 RADIOISOTOPE	1,265,638	23,911	45,975	137,159	1,472,683	56.00	
57.00 05700 CT SCAN	1,127,479	13,071	25,132	210,758	1,376,440	57.00	
58.00 05800 MRI	606,154	12,502	24,037	94,865	737,558	58.00	
59.00 05900 CARDIAC CATHETERIZATION	2,108,524	122,634	235,794	349,256	2,816,208	59.00	
60.00 06000 LABORATORY	9,912,249	14,918	28,684	4,341	9,960,192	60.00	
65.00 06500 RESPIRATORY THERAPY	1,573,758	15,127	29,086	338,646	1,956,617	65.00	
66.00 06600 PHYSICAL THERAPY	9,456,828	0	0	2,048,158	11,504,986	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,190,722	0	0	294,763	1,485,485	67.00	
68.00 06800 SPEECH PATHOLOGY	562,579	0	0	143,912	706,491	68.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
70.01 07001 SLEEP LAB/NEUROLOGY	37,332	2,591	4,982	8,417	53,322	70.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6,820,079	0	0	0	6,820,079	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12,043,935	0	0	0	12,043,935	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	15,986,220	0	0	0	15,986,220	73.00	
76.00 03140 CARDIOLOGY	490,892	17,207	33,085	119,185	660,369	76.00	
76.97 07697 CARDIAC REHABILITATION	652,374	0	0	130,089	782,463	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	24,611,218	20,879	40,144	103,919	24,776,160	90.00	
90.01 09001 DIABETES CENTER	218,007	0	0	49,629	267,636	90.01	
91.00 09100 EMERGENCY	5,834,824	109,877	211,265	1,163,907	7,319,873	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00	
OTHER REIMBURSABLE COST CENTERS							
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	781,280	0	0	109,056	890,336	97.00	
101.00 10100 HOME HEALTH AGENCY	3,417,522	0	0	781,078	4,198,600	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE						113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	253,161,008	3,417,956	6,571,846	21,466,159	253,111,463	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6	16,952	32,593	0	49,551	190.00	
192.01 19201 OCCUPATIONAL HEALTH	0	0	0	0	0	192.01	
192.02 19202 FLIGHT FOR LIFE	7,159	0	0	0	7,159	192.02	
192.04 19204 WELLNESS PROGRAM	0	0	0	0	0	192.04	
200.00	Cross Foot Adjustments				0	200.00	
201.00	Negative Cost Centers				0	201.00	
202.00	TOTAL (sum lines 118-201)	253,168,173	3,434,908	6,604,439	21,466,159	253,168,173	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part I Date/Time Prepared: 11/22/2016 12:45 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	47,110,421			5.00
7.00	00700	OPERATION OF PLANT	1,132,642	6,086,748		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	201,305	13,127	1,094,928	8.00
9.00	00900	HOUSEKEEPING	735,529	94,136	0	9.00
10.00	01000	DIETARY	589,432	244,540	0	10.00
11.00	01100	CAFETERIA	200,434	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	905,984	42,440	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	708,041	157,052	0	14.00
15.00	01500	PHARMACY	811,518	150,881	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	889,468	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,725,995	1,783,368	397,519	30.00
31.00	03100	INTENSIVE CARE UNIT	1,417,828	252,198	94,656	31.00
41.00	04100	SUBPROVIDER - IRF	885,791	241,174	17,610	41.00
43.00	04300	NURSERY	542,504	214,274	3,919	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,301,637	1,200,346	115,347	50.00
51.00	05100	RECOVERY ROOM	375,416	65,581	20,913	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,039,192	117,474	9,104	52.00
53.00	05300	ANESTHESIOLOGY	130,019	18,345	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,493,229	282,015	35,221	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	819,176	317,330	0	55.00
56.00	05600	RADIOISOTOPE	336,695	57,727	0	56.00
57.00	05700	CT SCAN	314,691	31,556	0	57.00
58.00	05800	MRI	168,626	30,182	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	643,861	296,068	77,046	59.00
60.00	06000	LABORATORY	2,277,169	36,016	0	60.00
65.00	06500	RESPIRATORY THERAPY	447,335	36,521	0	65.00
66.00	06600	PHYSICAL THERAPY	2,630,350	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	339,622	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	161,523	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	12,191	6,255	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,559,254	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,753,569	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,654,882	0	0	73.00
76.00	03140	CARDIOLOGY	150,978	41,542	0	76.00
76.97	07697	CARDIAC REHABILITATION	178,892	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,664,499	50,406	0	90.00
90.01	09001	DIABETES CENTER	61,189	0	0	90.01
91.00	09100	EMERGENCY	1,673,521	265,269	323,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS						
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	203,555	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	959,913	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,097,455	6,045,823	1,094,928	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,329	40,925	0	190.00
192.01	19201	OCCUPATIONAL HEALTH	0	0	0	192.01
192.02	19202	FLIGHT FOR LIFE	1,637	0	0	192.02
192.04	19204	WELLNESS PROGRAM	0	0	0	192.04
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	47,110,421	6,086,748	1,094,928	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part I Date/Time Prepared: 11/22/2016 12:45 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,077,118					11.00
13.00	01300	NURSING ADMINISTRATION	28,172	4,968,034				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,101	0	4,087,410			14.00
15.00	01500	PHARMACY	45,837	0	0	4,659,878		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	4,779,946	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	296,270	3,264,463	0	0	343,895	30.00
31.00	03100	INTENSIVE CARE UNIT	57,036	628,466	0	0	68,125	31.00
41.00	04100	SUBPROVIDER - IIRF	42,211	465,140	0	0	46,651	41.00
43.00	04300	NURSERY	16,112	177,484	0	0	22,794	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	98,640	0	0	0	460,021	50.00
51.00	05100	RECOVERY ROOM	12,741	0	0	0	57,524	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,905	0	0	0	52,955	52.00
53.00	05300	ANESTHESIOLOGY	1,074	0	0	0	58,747	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,615	0	0	0	529,875	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	22,887	0	0	0	135,396	55.00
56.00	05600	RADIOISOTOPE	5,956	0	0	0	78,816	56.00
57.00	05700	CT SCAN	10,635	0	0	0	326,431	57.00
58.00	05800	MRI	4,754	0	0	0	100,842	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,133	0	0	0	143,953	59.00
60.00	06000	LABORATORY	128	0	0	0	638,866	60.00
65.00	06500	RESPIRATORY THERAPY	20,919	230,474	0	0	52,745	65.00
66.00	06600	PHYSICAL THERAPY	111,455	0	0	0	282,932	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,783	0	0	0	34,166	67.00
68.00	06800	SPEECH PATHOLOGY	6,838	0	0	0	19,634	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	681	0	0	0	1,586	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,477,761	0	102,225	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,609,649	0	205,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,659,878	402,323	73.00
76.00	03140	CARDIOLOGY	6,062	66,776	0	0	23,207	76.00
76.97	07697	CARDIAC REHABILITATION	6,679	73,576	0	0	10,793	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,594	0	0	0	210,813	90.00
90.01	09001	DIABETES CENTER	3,042	0	0	0	2,699	90.01
91.00	09100	EMERGENCY	65,501	61,655	0	0	312,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	7,274	0	0	0	21,244	97.00
101.00	10100	HOME HEALTH AGENCY	43,083	0	0	0	32,517	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,077,118	4,968,034	4,087,410	4,659,878	4,779,946	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.01	19201	OCCUPATIONAL HEALTH	0	0	0	0	0	192.01
192.02	19202	FLIGHT FOR LIFE	0	0	0	0	0	192.02
192.04	19204	WELLNESS PROGRAM	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,077,118	4,968,034	4,087,410	4,659,878	4,779,946	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part I
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	40,715,727	0	40,715,727	30.00
31.00	03100	0	9,252,921	0	9,252,921	31.00
41.00	04100	0	6,299,007	0	6,299,007	41.00
43.00	04300	0	3,494,984	0	3,494,984	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	20,429,516	0	20,429,516	50.00
51.00	05100	0	2,218,604	0	2,218,604	51.00
52.00	05200	0	5,875,492	0	5,875,492	52.00
53.00	05300	0	789,293	0	789,293	53.00
54.00	05400	0	14,512,043	0	14,512,043	54.00
55.00	05500	0	5,092,579	0	5,092,579	55.00
56.00	05600	0	1,990,946	0	1,990,946	56.00
57.00	05700	0	2,081,110	0	2,081,110	57.00
58.00	05800	0	1,062,389	0	1,062,389	58.00
59.00	05900	0	4,193,643	0	4,193,643	59.00
60.00	06000	0	12,936,746	0	12,936,746	60.00
65.00	06500	0	2,769,328	0	2,769,328	65.00
66.00	06600	0	14,529,723	0	14,529,723	66.00
67.00	06700	0	1,874,056	0	1,874,056	67.00
68.00	06800	0	894,486	0	894,486	68.00
70.00	07000	0	0	0	0	70.00
70.01	07001	0	78,268	0	78,268	70.01
71.00	07100	0	9,959,319	0	9,959,319	71.00
72.00	07200	0	17,612,509	0	17,612,509	72.00
73.00	07300	0	24,703,303	0	24,703,303	73.00
76.00	03140	0	977,049	0	977,049	76.00
76.97	07697	0	1,052,403	0	1,052,403	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	30,741,586	0	30,741,586	90.00
90.01	09001	0	334,566	0	334,566	90.01
91.00	09100	0	10,201,757	0	10,201,757	91.00
92.00	09200	0		0		92.00
OTHER REIMBURSABLE COST CENTERS						
97.00	09700	0	1,122,409	0	1,122,409	97.00
101.00	10100	0	5,234,113	0	5,234,113	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	0		0		113.00
118.00		0	253,029,875	0	253,029,875	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	129,502	0	129,502	190.00
192.01	19201	0	0	0	0	192.01
192.02	19202	0	8,796	0	8,796	192.02
192.04	19204	0	0	0	0	192.04
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		0	253,168,173	0	253,168,173	202.00

Provider CCN: 140116

Period:
 From 07/01/2015
 To 06/30/2016

Worksheet Non-CMS W
 Date/Time Prepared:
 11/22/2016 12:45 pm

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	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	2	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	FTES	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NRSING	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet B
Part II
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,067	5,898	8,965	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	-376,041	633,933	1,218,890	1,476,782	5.00
7.00 00700	OPERATION OF PLANT	87,336	276,720	532,061	896,117	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,437	10,455	15,892	8.00
9.00 00900	HOUSEKEEPING	0	38,992	74,971	113,963	9.00
10.00 01000	DIETARY	18,738	101,291	194,756	314,785	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	22,661	17,579	33,800	74,040	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,067,065	65,052	125,079	1,257,196	14.00
15.00 01500	PHARMACY	682,674	62,496	120,164	865,334	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	13,566	0	0	13,566	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	35,069	738,688	1,420,303	2,194,060	30.00
31.00 03100	INTENSIVE CARE UNIT	6,712	104,463	200,855	312,030	31.00
41.00 04100	SUBPROVIDER - IRF	236	99,897	192,075	292,208	41.00
43.00 04300	NURSERY	0	88,754	170,652	259,406	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	139,179	497,194	955,976	1,592,349	50.00
51.00 05100	RECOVERY ROOM	0	27,164	52,230	79,394	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	48,659	93,558	142,217	52.00
53.00 05300	ANESTHESIOLOGY	12,338	7,599	14,610	34,547	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,145,561	116,813	224,602	1,486,976	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	43,042	131,441	252,727	427,210	55.00
56.00 05600	RADIOISOTOPE	2,037	23,911	45,975	71,923	56.00
57.00 05700	CT SCAN	0	13,071	25,132	38,203	57.00
58.00 05800	MRI	39,938	12,502	24,037	76,477	58.00
59.00 05900	CARDIAC CATHETERIZATION	7,589	122,634	235,794	366,017	59.00
60.00 06000	LABORATORY	6,040	14,918	28,684	49,642	60.00
65.00 06500	RESPIRATORY THERAPY	33,075	15,127	29,086	77,288	65.00
66.00 06600	PHYSICAL THERAPY	1,558,193	0	0	1,558,193	66.00
67.00 06700	OCCUPATIONAL THERAPY	72,877	0	0	72,877	67.00
68.00 06800	SPEECH PATHOLOGY	1,226	0	0	1,226	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	0	2,591	4,982	7,573	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	0	17,207	33,085	50,292	76.00
76.97 07697	CARDIAC REHABILITATION	191,749	0	0	191,749	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	5,137,399	20,879	40,144	5,198,422	90.00
90.01 09001	DIABETES CENTER	13,994	0	0	13,994	90.01
91.00 09100	EMERGENCY	18,118	109,877	211,265	339,260	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS						
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	1,488	0	0	1,488	97.00
101.00 10100	HOME HEALTH AGENCY	74,193	0	0	74,193	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,056,052	3,417,956	6,571,846	20,045,854	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,952	32,593	49,545	190.00
192.01 19201	OCCUPATIONAL HEALTH	0	0	0	0	192.01
192.02 19202	FLIGHT FOR LIFE	244	0	0	244	192.02
192.04 19204	WELLNESS PROGRAM	0	0	0	0	192.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	10,056,296	3,434,908	6,604,439	20,095,643	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/22/2016 12:45 pm
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,477,098				5.00
7.00	00700	OPERATION OF PLANT	35,511	931,794			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,311	2,010	24,217		8.00
9.00	00900	HOUSEKEEPING	23,061	14,411	0	151,620	9.00
10.00	01000	DIETARY	18,480	37,436	0	6,201	376,990
11.00	01100	CAFETERIA	6,284	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	28,405	6,497	0	1,076	0
14.00	01400	CENTRAL SERVICES & SUPPLY	22,199	24,042	0	3,982	0
15.00	01500	PHARMACY	25,443	23,098	0	3,826	0
16.00	01600	MEDICAL RECORDS & LIBRARY	27,887	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	179,597	273,006	8,793	45,222	279,492
31.00	03100	INTENSIVE CARE UNIT	44,452	38,608	2,093	6,395	38,192
41.00	04100	SUBPROVIDER - I RF	27,772	36,920	389	6,115	59,306
43.00	04300	NURSERY	17,009	32,802	87	5,433	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	103,514	183,756	2,551	30,437	0
51.00	05100	RECOVERY ROOM	11,770	10,040	463	1,663	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,581	17,984	201	2,979	0
53.00	05300	ANESTHESIOLOGY	4,076	2,808	0	465	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,169	43,172	779	7,151	0
55.00	05500	RADIOLOGY-THERAPEUTIC	25,683	48,579	0	8,046	0
56.00	05600	RADIOISOTOPE	10,556	8,837	0	1,464	0
57.00	05700	CT SCAN	9,866	4,831	0	800	0
58.00	05800	MRI	5,287	4,620	0	765	0
59.00	05900	CARDIAC CATHETERIZATION	20,187	45,324	1,704	7,507	0
60.00	06000	LABORATORY	71,395	5,514	0	913	0
65.00	06500	RESPIRATORY THERAPY	14,025	5,591	0	926	0
66.00	06600	PHYSICAL THERAPY	82,468	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	10,648	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	5,064	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	SLEEP LAB/NEUROLOGY	382	958	0	159	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,886	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,331	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	114,589	0	0	0	0
76.00	03140	CARDIOLOGY	4,734	6,360	0	1,053	0
76.97	07697	CARDIAC REHABILITATION	5,609	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	177,596	7,716	0	1,278	0
90.01	09001	DIABETES CENTER	1,918	0	0	0	0
91.00	09100	EMERGENCY	52,469	40,609	7,157	6,726	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	6,382	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	30,096	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,476,692	925,529	24,217	150,582	376,990
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355	6,265	0	1,038	0
192.01	19201	OCCUPATIONAL HEALTH	0	0	0	0	0
192.02	19202	FLIGHT FOR LIFE	51	0	0	0	0
192.04	19204	WELLNESS PROGRAM	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,477,098	931,794	24,217	151,620	376,990

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/22/2016 12:45 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	6,374					11.00
13.00	01300		110,434				13.00
14.00	01400	113	0	1,307,615			14.00
15.00	01500	271	0	0	918,382		15.00
16.00	01600	0	0	0	0	41,453	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,754	72,565	0	0	3,006	30.00
31.00	03100	338	13,970	0	0	596	31.00
41.00	04100	250	10,340	0	0	408	41.00
43.00	04300	95	3,945	0	0	199	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	584	0	0	0	4,021	50.00
51.00	05100	75	0	0	0	503	51.00
52.00	05200	189	0	0	0	463	52.00
53.00	05300	6	0	0	0	514	53.00
54.00	05400	447	0	0	0	4,632	54.00
55.00	05500	135	0	0	0	1,184	55.00
56.00	05600	35	0	0	0	689	56.00
57.00	05700	63	0	0	0	2,854	57.00
58.00	05800	28	0	0	0	882	58.00
59.00	05900	95	0	0	0	1,258	59.00
60.00	06000	1	0	0	0	5,250	60.00
65.00	06500	124	5,123	0	0	461	65.00
66.00	06600	660	0	0	0	2,473	66.00
67.00	06700	87	0	0	0	299	67.00
68.00	06800	40	0	0	0	172	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	4	0	0	0	14	70.01
71.00	07100	0	0	472,754	0	894	71.00
72.00	07200	0	0	834,861	0	1,795	72.00
73.00	07300	0	0	0	918,382	3,517	73.00
76.00	03140	36	1,484	0	0	203	76.00
76.97	07697	40	1,636	0	0	94	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	33	0	0	0	1,843	90.00
90.01	09001	18	0	0	0	24	90.01
91.00	09100	388	1,371	0	0	2,735	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	43	0	0	0	186	97.00
101.00	10100	255	0	0	0	284	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		6,374	110,434	1,307,615	918,382	41,453	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.04	19204	0	0	0	0	0	192.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		6,374	110,434	1,307,615	918,382	41,453	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/22/2016 12:45 pm		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,059,457	0	3,059,457
31.00	03100	INTENSIVE CARE UNIT	0	457,121	0	457,121
41.00	04100	SUBPROVIDER - IRF	0	434,007	0	434,007
43.00	04300	NURSERY	0	319,107	0	319,107
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,917,991	0	1,917,991
51.00	05100	RECOVERY ROOM	0	104,035	0	104,035
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	196,875	0	196,875
53.00	05300	ANESTHESIOLOGY	0	42,421	0	42,421
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,621,934	0	1,621,934
55.00	05500	RADIOLOGY-THERAPEUTIC	0	511,053	0	511,053
56.00	05600	RADIOISOTOPE	0	93,561	0	93,561
57.00	05700	CT SCAN	0	56,705	0	56,705
58.00	05800	MRI	0	88,099	0	88,099
59.00	05900	CARDIAC CATHETERIZATION	0	442,238	0	442,238
60.00	06000	LABORATORY	0	132,717	0	132,717
65.00	06500	RESPIRATORY THERAPY	0	103,679	0	103,679
66.00	06600	PHYSICAL THERAPY	0	1,644,648	0	1,644,648
67.00	06700	OCCUPATIONAL THERAPY	0	84,034	0	84,034
68.00	06800	SPEECH PATHOLOGY	0	6,562	0	6,562
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
70.01	07001	SLEEP LAB/NEUROLOGY	0	9,094	0	9,094
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	522,534	0	522,534
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	922,987	0	922,987
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,036,488	0	1,036,488
76.00	03140	CARDIOLOGY	0	64,212	0	64,212
76.97	07697	CARDIAC REHABILITATION	0	199,182	0	199,182
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,386,931	0	5,386,931
90.01	09001	DIABETES CENTER	0	15,975	0	15,975
91.00	09100	EMERGENCY	0	451,200	0	451,200
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	
OTHER REIMBURSABLE COST CENTERS						
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	8,144	0	8,144
101.00	10100	HOME HEALTH AGENCY	0	105,154	0	105,154
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	20,038,145	0	20,038,145
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57,203	0	57,203
192.01	19201	OCCUPATIONAL HEALTH	0	0	0	0
192.02	19202	FLIGHT FOR LIFE	0	295	0	295
192.04	19204	WELLNESS PROGRAM	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	20,095,643	0	20,095,643

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	295,639				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		295,639			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	264	264	82,145,693		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	54,562	54,562	2,900,163	-47,110,421	5.00
7.00 00700	OPERATION OF PLANT	23,817	23,817	1,524,120	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	468	468	39,703	0	8.00
9.00 00900	HOUSEKEEPING	3,356	3,356	1,700,480	0	9.00
10.00 01000	DIETARY	8,718	8,718	804,410	0	10.00
11.00 01100	CAFETERIA	0	0	826,363	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,513	1,513	2,285,911	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	5,599	5,599	760,506	0	14.00
15.00 01500	PHARMACY	5,379	5,379	3,764,105	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	63,578	63,578	17,889,528	0	30.00
31.00 03100	INTENSIVE CARE UNIT	8,991	8,991	4,103,159	0	31.00
41.00 04100	SUBPROVIDER - IRF	8,598	8,598	2,742,287	0	41.00
43.00 04300	NURSERY	7,639	7,639	1,200,610	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	42,793	42,793	7,149,797	0	50.00
51.00 05100	RECOVERY ROOM	2,338	2,338	1,162,646	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,188	4,188	2,395,619	0	52.00
53.00 05300	ANESTHESIOLOGY	654	654	42,947	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,054	10,054	5,582,277	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	11,313	11,313	1,977,079	0	55.00
56.00 05600	RADIOISOTOPE	2,058	2,058	524,873	0	56.00
57.00 05700	CT SCAN	1,125	1,125	806,521	0	57.00
58.00 05800	MRI	1,076	1,076	363,024	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	10,555	10,555	1,336,516	0	59.00
60.00 06000	LABORATORY	1,284	1,284	16,613	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,302	1,302	1,295,916	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	7,837,798	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	1,127,985	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	550,715	0	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	223	223	32,208	0	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	1,481	1,481	456,091	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	497,817	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,797	1,797	397,671	0	90.00
90.01 09001	DIABETES CENTER	0	0	189,919	0	90.01
91.00 09100	EMERGENCY	9,457	9,457	4,453,989	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0	417,332	0	97.00
101.00 10100	HOME HEALTH AGENCY	0	0	2,988,995	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	294,180	294,180	82,145,693	-47,110,421	206,001,042
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,459	1,459	0	0	190.00
192.01 19201	OCCUPATIONAL HEALTH	0	0	0	0	192.01
192.02 19202	FLIGHT FOR LIFE	0	0	0	0	192.02
192.04 19204	WELLNESS PROGRAM	0	0	0	0	192.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,434,908	6,604,439	21,466,159		47,110,421
203.00	Unit cost multiplier (Wkst. B, Part I)	11.618589	22.339539	0.261318		0.228627
204.00	Cost to be allocated (per Wkst. B, Part II)			8,965		1,477,098
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000109		0.007168

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:

11/22/2016 12:45 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	216,996				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	468	1,381,976			8.00	
9.00	00900	HOUSEKEEPING	3,356	0	213,172		9.00	
10.00	01000	DIETARY	8,718	0	8,718	333,579	10.00	
11.00	01100	CAFETERIA	0	0	0	101,280	11.00	
13.00	01300	NURSING ADMINISTRATION	1,513	0	1,513	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	5,599	0	5,599	0	14.00	
15.00	01500	PHARMACY	5,379	0	5,379	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	63,578	501,735	63,578	247,308	27,858	30.00
31.00	03100	INTENSIVE CARE UNIT	8,991	119,471	8,991	33,794	5,363	31.00
41.00	04100	SUBPROVIDER - IRF	8,598	22,227	8,598	52,477	3,969	41.00
43.00	04300	NURSERY	7,639	4,946	7,639	0	1,515	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	42,793	145,587	42,793	0	9,275	50.00
51.00	05100	RECOVERY ROOM	2,338	26,395	2,338	0	1,198	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,188	11,491	4,188	0	3,000	52.00
53.00	05300	ANESTHESIOLOGY	654	0	654	0	101	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,054	44,454	10,054	0	7,110	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,313	0	11,313	0	2,152	55.00
56.00	05600	RADIOISOTOPE	2,058	0	2,058	0	560	56.00
57.00	05700	CT SCAN	1,125	0	1,125	0	1,000	57.00
58.00	05800	MRI	1,076	0	1,076	0	447	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,555	97,244	10,555	0	1,517	59.00
60.00	06000	LABORATORY	1,284	0	1,284	0	12	60.00
65.00	06500	RESPIRATORY THERAPY	1,302	0	1,302	0	1,967	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	10,480	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,390	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	643	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	223	0	223	0	64	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	1,481	0	1,481	0	570	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	628	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,797	0	1,797	0	526	90.00
90.01	09001	DIABETES CENTER	0	0	0	0	286	90.01
91.00	09100	EMERGENCY	9,457	408,426	9,457	0	6,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	684	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	4,051	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	215,537	1,381,976	211,713	333,579	101,280	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,459	0	1,459	0	0	190.00
192.01	19201	OCCUPATIONAL HEALTH	0	0	0	0	0	192.01
192.02	19202	FLIGHT FOR LIFE	0	0	0	0	0	192.02
192.04	19204	WELLNESS PROGRAM	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,086,748	1,094,928	4,046,824	3,577,613	1,077,118	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.050047	0.792292	18.983844	10.724935	10.635051	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	931,794	24,217	151,620	376,990	6,374	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.294061	0.017523	0.711257	1.130137	0.062934	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet B-1

Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	881,844					13.00
14.00	01400	0	18,864,014				14.00
15.00	01500	0	0	15,986,220			15.00
16.00	01600	0	0	0	908,472,055		16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	579,454	0	0	65,354,402	0	30.00
31.00	03100	111,555	0	0	12,946,587	0	31.00
41.00	04100	82,564	0	0	8,865,582	0	41.00
43.00	04300	31,504	0	0	4,331,853	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	87,423,304	0	50.00
51.00	05100	0	0	0	10,931,987	0	51.00
52.00	05200	0	0	0	10,063,691	0	52.00
53.00	05300	0	0	0	11,164,319	0	53.00
54.00	05400	0	0	0	100,698,349	0	54.00
55.00	05500	0	0	0	25,730,831	0	55.00
56.00	05600	0	0	0	14,978,317	0	56.00
57.00	05700	0	0	0	62,035,553	0	57.00
58.00	05800	0	0	0	19,164,276	0	58.00
59.00	05900	0	0	0	27,357,021	0	59.00
60.00	06000	0	0	0	121,493,858	0	60.00
65.00	06500	40,910	0	0	10,023,752	0	65.00
66.00	06600	0	0	0	53,768,922	0	66.00
67.00	06700	0	0	0	6,492,884	0	67.00
68.00	06800	0	0	0	3,731,320	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	0	0	0	301,472	0	70.01
71.00	07100	0	6,820,079	0	19,427,001	0	71.00
72.00	07200	0	12,043,935	0	39,026,138	0	72.00
73.00	07300	0	0	15,986,220	76,458,277	0	73.00
76.00	03140	11,853	0	0	4,410,328	0	76.00
76.97	07697	13,060	0	0	2,051,061	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	40,063,334	0	90.00
90.01	09001	0	0	0	512,993	0	90.01
91.00	09100	10,944	0	0	59,447,866	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	0	0	0	4,037,177	0	97.00
101.00	10100	0	0	0	6,179,600	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		881,844	18,864,014	15,986,220	908,472,055	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.04	19204	0	0	0	0	0	192.04
200.00							200.00
201.00							201.00
202.00		4,968,034	4,087,410	4,659,878	4,779,946	0	202.00
203.00		5.633688	0.216678	0.291493	0.005262	0.000000	203.00
204.00		110,434	1,307,615	918,382	41,453	0	204.00
205.00		0.125231	0.069318	0.057448	0.000046	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/22/2016 12:45 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		40,715,727	130,381	40,846,108	30.00	
31.00	03100 INTENSIVE CARE UNIT		9,252,921	0	9,252,921	31.00	
41.00	04100 SUBPROVIDER - I RF		6,299,007	0	6,299,007	41.00	
43.00	04300 NURSERY		3,494,984	0	3,494,984	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		20,429,516	0	20,429,516	50.00	
51.00	05100 RECOVERY ROOM		2,218,604	0	2,218,604	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		5,875,492	0	5,875,492	52.00	
53.00	05300 ANESTHESIOLOGY		789,293	12,926	802,219	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		14,512,043	55,527	14,567,570	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC		5,092,579	15,389	5,107,968	55.00	
56.00	05600 RADIOISOTOPE		1,990,946	0	1,990,946	56.00	
57.00	05700 CT SCAN		2,081,110	0	2,081,110	57.00	
58.00	05800 MRI		1,062,389	0	1,062,389	58.00	
59.00	05900 CARDIAC CATHETERIZATION		4,193,643	5,625	4,199,268	59.00	
60.00	06000 LABORATORY		12,936,746	0	12,936,746	60.00	
65.00	06500 RESPIRATORY THERAPY	0	2,769,328	0	2,769,328	65.00	
66.00	06600 PHYSICAL THERAPY	0	14,529,723	17,543	14,547,266	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	1,874,056	0	1,874,056	67.00	
68.00	06800 SPEECH PATHOLOGY	0	894,486	0	894,486	68.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
70.01	07001 SLEEP LAB/NEUROLOGY		78,268	0	78,268	70.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		9,959,319	0	9,959,319	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		17,612,509	0	17,612,509	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		24,703,303	0	24,703,303	73.00	
76.00	03140 RADIOLOGY		977,049	0	977,049	76.00	
76.97	07697 CARDIAC REHABILITATION		1,052,403	704	1,053,107	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		30,741,586	43,613	30,785,199	90.00	
90.01	09001 DIABETES CENTER		334,566	238	334,804	90.01	
91.00	09100 EMERGENCY		10,201,757	25,729	10,227,486	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4,869,157	0	4,869,157	92.00	
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		1,122,409	0	1,122,409	97.00	
101.00	10100 HOME HEALTH AGENCY		5,234,113	0	5,234,113	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)	0	257,899,032	307,675	258,206,707	200.00	
201.00	Less Observation Beds		4,869,157	0	4,869,157	201.00	
202.00	Total (see instructions)	0	253,029,875	307,675	253,337,550	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/22/2016 12:45 pm	
			Title XVIIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	58,887,958		58,887,958			30.00
31.00	03100	INTENSIVE CARE UNIT	12,946,587		12,946,587			31.00
41.00	04100	SUBPROVIDER - IRF	8,865,582		8,865,582			41.00
43.00	04300	NURSERY	4,331,853		4,331,853			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,139,424	56,283,880	87,423,304	0.233685	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,604,397	6,327,590	10,931,987	0.202946	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,335,632	1,728,059	10,063,691	0.583831	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,569,085	6,595,234	11,164,319	0.070698	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,182,262	87,516,087	100,698,349	0.144114	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	890,840	24,839,991	25,730,831	0.197917	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,869,814	13,108,503	14,978,317	0.132922	0.000000	56.00
57.00	05700	CT SCAN	17,033,201	45,002,352	62,035,553	0.033547	0.000000	57.00
58.00	05800	MRI	2,542,621	16,621,655	19,164,276	0.055436	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,433,119	11,923,902	27,357,021	0.153293	0.000000	59.00
60.00	06000	LABORATORY	37,436,876	84,056,982	121,493,858	0.106481	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,612,358	1,411,394	10,023,752	0.276277	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,700,946	46,067,976	53,768,922	0.270225	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,514,788	978,096	6,492,884	0.288632	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,682,148	49,172	3,731,320	0.239724	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	140,896	160,576	301,472	0.259619	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,080,083	9,346,918	19,427,001	0.512653	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,670,437	12,355,701	39,026,138	0.451300	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,177,930	41,280,347	76,458,277	0.323095	0.000000	73.00
76.00	03140	CARDIOLOGY	617,133	3,793,195	4,410,328	0.221537	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	141,246	1,909,815	2,051,061	0.513102	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	14,771	40,048,563	40,063,334	0.767325	0.000000	90.00
90.01	09001	DIABETES CENTER	0	512,993	512,993	0.652184	0.000000	90.01
91.00	09100	EMERGENCY	16,359,076	43,088,790	59,447,866	0.171608	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,466,444	6,466,444	0.752988	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	4,037,177	4,037,177	0.278018	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	6,179,600	6,179,600			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	336,781,063	571,690,992	908,472,055			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	336,781,063	571,690,992	908,472,055			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.233685		50.00
51.00	05100 RECOVERY ROOM	0.202946		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.583831		52.00
53.00	05300 ANESTHESIOLOGY	0.071856		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.144665		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.198515		55.00
56.00	05600 RADIOISOTOPE	0.132922		56.00
57.00	05700 CT SCAN	0.033547		57.00
58.00	05800 MRI	0.055436		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.153499		59.00
60.00	06000 LABORATORY	0.106481		60.00
65.00	06500 RESPIRATORY THERAPY	0.276277		65.00
66.00	06600 PHYSICAL THERAPY	0.270552		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.288632		67.00
68.00	06800 SPEECH PATHOLOGY	0.239724		68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.259619		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.512653		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451300		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.323095		73.00
76.00	03140 RADIOLOGY	0.221537		76.00
76.97	07697 CARDIAC REHABILITATION	0.513445		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.768413		90.00
90.01	09001 DIABETES CENTER	0.652648		90.01
91.00	09100 EMERGENCY	0.172041		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.752988		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.278018		97.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
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: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet C
Part I
Date/Time Prepared:
11/22/2016 12:45 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	40,715,727	40,715,727	130,381	40,846,108	30.00
31.00	03100 INTENSIVE CARE UNIT	9,252,921	9,252,921	0	9,252,921	31.00
41.00	04100 SUBPROVIDER - I RF	6,299,007	6,299,007	0	6,299,007	41.00
43.00	04300 NURSERY	3,494,984	3,494,984	0	3,494,984	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	20,429,516	20,429,516	0	20,429,516	50.00
51.00	05100 RECOVERY ROOM	2,218,604	2,218,604	0	2,218,604	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,875,492	5,875,492	0	5,875,492	52.00
53.00	05300 ANESTHESIOLOGY	789,293	789,293	12,926	802,219	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	14,512,043	14,512,043	55,527	14,567,570	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	5,092,579	5,092,579	15,389	5,107,968	55.00
56.00	05600 RADIOISOTOPE	1,990,946	1,990,946	0	1,990,946	56.00
57.00	05700 CT SCAN	2,081,110	2,081,110	0	2,081,110	57.00
58.00	05800 MRI	1,062,389	1,062,389	0	1,062,389	58.00
59.00	05900 CARDIAC CATHETERIZATION	4,193,643	4,193,643	5,625	4,199,268	59.00
60.00	06000 LABORATORY	12,936,746	12,936,746	0	12,936,746	60.00
65.00	06500 RESPIRATORY THERAPY	2,769,328	2,769,328	0	2,769,328	65.00
66.00	06600 PHYSICAL THERAPY	14,529,723	14,529,723	17,543	14,547,266	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,874,056	1,874,056	0	1,874,056	67.00
68.00	06800 SPEECH PATHOLOGY	894,486	894,486	0	894,486	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	78,268	78,268	0	78,268	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,959,319	9,959,319	0	9,959,319	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17,612,509	17,612,509	0	17,612,509	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	24,703,303	24,703,303	0	24,703,303	73.00
76.00	03140 RADIOLOGY	977,049	977,049	0	977,049	76.00
76.97	07697 CARDIAC REHABILITATION	1,052,403	1,052,403	704	1,053,107	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	30,741,586	30,741,586	43,613	30,785,199	90.00
90.01	09001 DIABETES CENTER	334,566	334,566	238	334,804	90.01
91.00	09100 EMERGENCY	10,201,757	10,201,757	25,729	10,227,486	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,869,157	4,869,157	0	4,869,157	92.00
OTHER REIMBURSABLE COST CENTERS						
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	1,122,409	1,122,409	0	1,122,409	97.00
101.00	10100 HOME HEALTH AGENCY	5,234,113	5,234,113	0	5,234,113	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	257,899,032	257,899,032	307,675	258,206,707	200.00
201.00	Less Observation Beds	4,869,157	4,869,157	0	4,869,157	201.00
202.00	Total (see instructions)	253,029,875	253,029,875	307,675	253,337,550	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/22/2016 12:45 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	58,887,958		58,887,958			30.00
31.00	03100	INTENSIVE CARE UNIT	12,946,587		12,946,587			31.00
41.00	04100	SUBPROVIDER - IRF	8,865,582		8,865,582			41.00
43.00	04300	NURSERY	4,331,853		4,331,853			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,139,424	56,283,880	87,423,304	0.233685	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,604,397	6,327,590	10,931,987	0.202946	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,335,632	1,728,059	10,063,691	0.583831	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	4,569,085	6,595,234	11,164,319	0.070698	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,182,262	87,516,087	100,698,349	0.144114	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	890,840	24,839,991	25,730,831	0.197917	0.000000	55.00
56.00	05600	RADIOISOTOPE	1,869,814	13,108,503	14,978,317	0.132922	0.000000	56.00
57.00	05700	CT SCAN	17,033,201	45,002,352	62,035,553	0.033547	0.000000	57.00
58.00	05800	MRI	2,542,621	16,621,655	19,164,276	0.055436	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,433,119	11,923,902	27,357,021	0.153293	0.000000	59.00
60.00	06000	LABORATORY	37,436,876	84,056,982	121,493,858	0.106481	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,612,358	1,411,394	10,023,752	0.276277	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	7,700,946	46,067,976	53,768,922	0.270225	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,514,788	978,096	6,492,884	0.288632	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,682,148	49,172	3,731,320	0.239724	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	140,896	160,576	301,472	0.259619	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,080,083	9,346,918	19,427,001	0.512653	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,670,437	12,355,701	39,026,138	0.451300	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,177,930	41,280,347	76,458,277	0.323095	0.000000	73.00
76.00	03140	CARDIOLOGY	617,133	3,793,195	4,410,328	0.221537	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	141,246	1,909,815	2,051,061	0.513102	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	14,771	40,048,563	40,063,334	0.767325	0.000000	90.00
90.01	09001	DIABETES CENTER	0	512,993	512,993	0.652184	0.000000	90.01
91.00	09100	EMERGENCY	16,359,076	43,088,790	59,447,866	0.171608	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,466,444	6,466,444	0.752988	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	4,037,177	4,037,177	0.278018	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	6,179,600	6,179,600			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	336,781,063	571,690,992	908,472,055			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	336,781,063	571,690,992	908,472,055			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/22/2016 12:45 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.000000		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03140 RADIOLOGY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 DIABETES CENTER	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		97.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
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: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part I Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,059,457	0	3,059,457	35,065	87.25	30.00	
31.00	INTENSIVE CARE UNIT	457,121	0	457,121	4,294	106.46	31.00	
41.00	SUBPROVIDER - IRF	434,007	0	434,007	6,668	65.09	41.00	
43.00	NURSERY	319,107		319,107	3,777	84.49	43.00	
200.00	Total (Lines 30-199)	4,269,692		4,269,692	49,804		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	15,808	1,379,248					30.00
31.00	INTENSIVE CARE UNIT	2,301	244,964					31.00
41.00	SUBPROVIDER - IRF	4,802	312,562					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (Lines 30-199)	22,911	1,936,774					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/22/2016 12:45 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,917,991	87,423,304	0.021939	15,226,733	334,059	50.00
51.00	05100	RECOVERY ROOM	104,035	10,931,987	0.009517	2,163,151	20,587	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	196,875	10,063,691	0.019563	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,421	11,164,319	0.003800	1,995,187	7,582	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,621,934	100,698,349	0.016107	7,583,429	122,146	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	511,053	25,730,831	0.019862	500,065	9,932	55.00
56.00	05600	RADIOISOTOPE	93,561	14,978,317	0.006246	1,127,561	7,043	56.00
57.00	05700	CT SCAN	56,705	62,035,553	0.000914	8,996,286	8,223	57.00
58.00	05800	MRI	88,099	19,164,276	0.004597	1,268,587	5,832	58.00
59.00	05900	CARDIAC CATHETERIZATION	442,238	27,357,021	0.016165	7,232,062	116,906	59.00
60.00	06000	LABORATORY	132,717	121,493,858	0.001092	18,672,457	20,390	60.00
65.00	06500	RESPIRATORY THERAPY	103,679	10,023,752	0.010343	4,734,277	48,967	65.00
66.00	06600	PHYSICAL THERAPY	1,644,648	53,768,922	0.030587	2,671,568	81,715	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,034	6,492,884	0.012942	1,449,360	18,758	67.00
68.00	06800	SPEECH PATHOLOGY	6,562	3,731,320	0.001759	890,742	1,567	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	9,094	301,472	0.030165	74,900	2,259	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	522,534	19,427,001	0.026897	5,148,641	138,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	922,987	39,026,138	0.023650	13,188,747	311,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,036,488	76,458,277	0.013556	16,673,278	226,023	73.00
76.00	03140	CARDIOLOGY	64,212	4,410,328	0.014559	369,068	5,373	76.00
76.97	07697	CARDIAC REHABILITATION	199,182	2,051,061	0.097112	70,276	6,825	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,386,931	40,063,334	0.134460	11,716	1,575	90.00
90.01	09001	DIABETES CENTER	15,975	512,993	0.031141	0	0	90.01
91.00	09100	EMERGENCY	451,200	59,447,866	0.007590	9,046,889	68,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	364,710	6,466,444	0.056400	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	8,144	4,037,177	0.002017	0	0	97.00
200.00		Total (lines 50-199)	16,028,009	817,260,475		119,094,980	1,564,825	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part III Date/Time Prepared: 11/22/2016 12:45 pm
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Cost Center Description			Title XVIII		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0 31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00	
43.00	04300	NURSERY	0	0	0	0	0 43.00	
200.00		Total (lines 30-199)	0	0	0	0	0 200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	35,065	0.00	15,808	0	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	4,294	0.00	2,301	0	0 31.00	
41.00	04100	SUBPROVIDER - IRF	6,668	0.00	4,802	0	0 41.00	
43.00	04300	NURSERY	3,777	0.00	0	0	0 43.00	
200.00		Total (lines 30-199)	49,804		22,911	0	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			
43.00	04300	NURSERY	0	0	43.00			
200.00		Total (lines 30-199)	0	0	200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	DIABETES CENTER	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 12:45 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	87,423,304	0.000000	0.000000	15,226,733	50.00
51.00	05100 RECOVERY ROOM	0	10,931,987	0.000000	0.000000	2,163,151	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	10,063,691	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	11,164,319	0.000000	0.000000	1,995,187	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	100,698,349	0.000000	0.000000	7,583,429	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	25,730,831	0.000000	0.000000	500,065	55.00
56.00	05600 RADIOISOTOPE	0	14,978,317	0.000000	0.000000	1,127,561	56.00
57.00	05700 CT SCAN	0	62,035,553	0.000000	0.000000	8,996,286	57.00
58.00	05800 MRI	0	19,164,276	0.000000	0.000000	1,268,587	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	27,357,021	0.000000	0.000000	7,232,062	59.00
60.00	06000 LABORATORY	0	121,493,858	0.000000	0.000000	18,672,457	60.00
65.00	06500 RESPIRATORY THERAPY	0	10,023,752	0.000000	0.000000	4,734,277	65.00
66.00	06600 PHYSICAL THERAPY	0	53,768,922	0.000000	0.000000	2,671,568	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	6,492,884	0.000000	0.000000	1,449,360	67.00
68.00	06800 SPEECH PATHOLOGY	0	3,731,320	0.000000	0.000000	890,742	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	301,472	0.000000	0.000000	74,900	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,427,001	0.000000	0.000000	5,148,641	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	39,026,138	0.000000	0.000000	13,188,747	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	76,458,277	0.000000	0.000000	16,673,278	73.00
76.00	03140 RADIOLOGY	0	4,410,328	0.000000	0.000000	369,068	76.00
76.97	07697 CARDIAC REHABILITATION	0	2,051,061	0.000000	0.000000	70,276	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	40,063,334	0.000000	0.000000	11,716	90.00
90.01	09001 DIABETES CENTER	0	512,993	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	59,447,866	0.000000	0.000000	9,046,889	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6,466,444	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	4,037,177	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	817,260,475			119,094,980	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:45 pm

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	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	16,034,589	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,106,523	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,439,905	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,127,387	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,909,716	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	6,153,847	0	0	0	56.00
57.00	05700	CT SCAN	0	12,783,108	0	0	0	57.00
58.00	05800	MRI	0	4,316,940	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,040,876	0	0	0	59.00
60.00	06000	LABORATORY	0	7,506,047	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	426,106	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	65,344	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,592	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,340	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	31,463	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,899,020	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,990,868	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,798,081	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	1,426,623	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	933,476	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	18,099,885	0	0	0	90.00
90.01	09001	DIABETES CENTER	0	81,313	0	0	0	90.01
91.00	09100	EMERGENCY	0	8,432,119	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,276,363	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	143,889,531	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		PSA Adj .	PSA Adj . All	Hospital	PPS
		Allied Health	Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	DIABETES CENTER	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00		Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.233685	16,034,589	0	0	3,747,043	50.00
51.00	05100 RECOVERY ROOM	0.202946	1,106,523	0	0	224,564	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.583831	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.070698	1,439,905	0	0	101,798	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.144114	23,127,387	0	0	3,332,980	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.197917	12,909,716	0	0	2,555,052	55.00
56.00	05600 RADIOISOTOPE	0.132922	6,153,847	0	0	817,982	56.00
57.00	05700 CT SCAN	0.033547	12,783,108	0	0	428,835	57.00
58.00	05800 MRI	0.055436	4,316,940	0	0	239,314	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.153293	5,040,876	0	0	772,731	59.00
60.00	06000 LABORATORY	0.106481	7,506,047	2,604	0	799,251	60.00
65.00	06500 RESPIRATORY THERAPY	0.276277	426,106	122	0	117,723	65.00
66.00	06600 PHYSICAL THERAPY	0.270225	65,344	0	0	17,658	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.288632	8,592	0	0	2,480	67.00
68.00	06800 SPEECH PATHOLOGY	0.239724	1,340	0	0	321	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.259619	31,463	0	0	8,168	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.512653	1,899,020	70	0	973,538	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451300	4,990,868	0	0	2,252,379	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.323095	14,798,081	1,290	639,786	4,781,186	73.00
76.00	03140 RADIOLOGY	0.221537	1,426,623	0	0	316,050	76.00
76.97	07697 CARDIAC REHABILITATION	0.513102	933,476	0	0	478,968	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.767325	18,099,885	174	0	13,888,494	90.00
90.01	09001 DIABETES CENTER	0.652184	81,313	0	0	53,031	90.01
91.00	09100 EMERGENCY	0.171608	8,432,119	0	0	1,447,019	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.752988	2,276,363	0	7,139	1,714,074	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.278018	0	0	0	0	97.00
200.00	Subtotal (see instructions)		143,889,531	4,260	646,925	39,070,639	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		143,889,531	4,260	646,925	39,070,639	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 12:45 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	277	0		60.00
65.00 06500 RESPIRATORY THERAPY	34	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	36	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	417	206,712		73.00
76.00 03140 RADIOLOGY	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	134	0		90.00
90.01 09001 DIABETES CENTER	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5,376		92.00
OTHER REIMBURSABLE COST CENTERS				
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Subtotal (see instructions)	898	212,088		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	898	212,088		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140116 Component CCN: 14T116		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part II Date/Time Prepared: 11/22/2016 12:45 pm	
		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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,917,991	87,423,304	0.021939	0	0 50.00
51.00	05100	RECOVERY ROOM	104,035	10,931,987	0.009517	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	196,875	10,063,691	0.019563	0	0 52.00
53.00	05300	ANESTHESIOLOGY	42,421	11,164,319	0.003800	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,621,934	100,698,349	0.016107	139,243	2,243 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	511,053	25,730,831	0.019862	64,214	1,275 55.00
56.00	05600	RADIOISOTOPE	93,561	14,978,317	0.006246	0	0 56.00
57.00	05700	CT SCAN	56,705	62,035,553	0.000914	105,500	96 57.00
58.00	05800	MRI	88,099	19,164,276	0.004597	23,272	107 58.00
59.00	05900	CARDIAC CATHETERIZATION	442,238	27,357,021	0.016165	0	0 59.00
60.00	06000	LABORATORY	132,717	121,493,858	0.001092	1,042,961	1,139 60.00
65.00	06500	RESPIRATORY THERAPY	103,679	10,023,752	0.010343	178,383	1,845 65.00
66.00	06600	PHYSICAL THERAPY	1,644,648	53,768,922	0.030587	2,377,770	72,729 66.00
67.00	06700	OCCUPATIONAL THERAPY	84,034	6,492,884	0.012942	2,285,214	29,575 67.00
68.00	06800	SPEECH PATHOLOGY	6,562	3,731,320	0.001759	1,752,690	3,083 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
70.01	07001	SLEEP LAB/NEUROLOGY	9,094	301,472	0.030165	0	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	522,534	19,427,001	0.026897	10,237	275 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	922,987	39,026,138	0.023650	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,036,488	76,458,277	0.013556	1,021,750	13,851 73.00
76.00	03140	CARDIOLOGY	64,212	4,410,328	0.014559	1,577	23 76.00
76.97	07697	CARDIAC REHABILITATION	199,182	2,051,061	0.097112	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	5,386,931	40,063,334	0.134460	0	0 90.00
90.01	09001	DIABETES CENTER	15,975	512,993	0.031141	0	0 90.01
91.00	09100	EMERGENCY	451,200	59,447,866	0.007590	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,466,444	0.000000	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	8,144	4,037,177	0.002017	0	0 97.00
200.00		Total (lines 50-199)	15,663,299	817,260,475		9,002,811	126,241 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:45 pm

Component CCN: 14T116

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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	DIABETES CENTER	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140116 Component CCN: 14T116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 12:45 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	87,423,304	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	10,931,987	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	10,063,691	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	11,164,319	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	100,698,349	0.000000	0.000000	139,243	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	25,730,831	0.000000	0.000000	64,214	55.00
56.00	05600 RADIOISOTOPE	0	14,978,317	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	62,035,553	0.000000	0.000000	105,500	57.00
58.00	05800 MRI	0	19,164,276	0.000000	0.000000	23,272	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	27,357,021	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	121,493,858	0.000000	0.000000	1,042,961	60.00
65.00	06500 RESPIRATORY THERAPY	0	10,023,752	0.000000	0.000000	178,383	65.00
66.00	06600 PHYSICAL THERAPY	0	53,768,922	0.000000	0.000000	2,377,770	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	6,492,884	0.000000	0.000000	2,285,214	67.00
68.00	06800 SPEECH PATHOLOGY	0	3,731,320	0.000000	0.000000	1,752,690	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	301,472	0.000000	0.000000	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,427,001	0.000000	0.000000	10,237	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	39,026,138	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	76,458,277	0.000000	0.000000	1,021,750	73.00
76.00	03140 RADIOLOGY	0	4,410,328	0.000000	0.000000	1,577	76.00
76.97	07697 CARDIAC REHABILITATION	0	2,051,061	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	40,063,334	0.000000	0.000000	0	90.00
90.01	09001 DIABETES CENTER	0	512,993	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	59,447,866	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6,466,444	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	4,037,177	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	817,260,475			9,002,811	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:45 pm
PPS

Component CCN: 14T116

Title XVIII

Subprovider - IRF

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	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	654	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES CENTER	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	654	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140116

Period: From 07/01/2015

Worksheet D

Component CCN: 14T116

To 06/30/2016

Part IV

Date/Time Prepared: 11/22/2016 12:45 pm

Title XVIII

Subprovider - IRF

PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
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
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03140 CARDIOLOGY	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 DIABETES CENTER	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 12:45 pm
		Component CCN: 14T116	Title XVIII	Subprovider - IRF
				PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.233685	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.202946	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.583831	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.070698	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144114	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.197917	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.132922	0	0	0	56.00
57.00	05700	CT SCAN	0.033547	0	0	0	57.00
58.00	05800	MRI	0.055436	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.153293	0	0	0	59.00
60.00	06000	LABORATORY	0.106481	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.276277	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.270225	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288632	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.239724	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.259619	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.512653	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451300	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323095	654	0	691	211 73.00
76.00	03140	CARDIOLOGY	0.221537	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.513102	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.767325	0	0	0	90.00
90.01	09001	DIABETES CENTER	0.652184	0	0	0	90.01
91.00	09100	EMERGENCY	0.171608	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.752988	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.278018	0	0	0	97.00
200.00		Subtotal (see instructions)		654	0	691	211 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		654	0	691	211 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 12:45 pm
	Component CCN: 14T116	Title XVIII	Subprovider - IRF

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
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
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	223	73.00
76.00 03140 RADIOLOGY	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 DIABETES CENTER	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00 Subtotal (see instructions)	0	223	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	223	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Hospital	PPS
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		35,065	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		35,065	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)		30,885	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)		15,808	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		40,846,108	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)		40,846,108	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		40,846,108	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,164.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		18,414,265	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)		18,414,265	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/22/2016 12:45 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	9,252,921	4,294	2,154.85	2,301	4,958,310		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)					27,301,296		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					50,673,871		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,624,212		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,564,825		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,189,037		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					47,484,834		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)					4,180		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,164.87		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,869,157		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet D-1

Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		Cost	Title XVIII		Hospital	PPS
			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	3,059,457	40,846,108	0.074902	4,869,157	364,710
91.00	Nursing School cost	0	40,846,108	0.000000	4,869,157	0
92.00	Allied health cost	0	40,846,108	0.000000	4,869,157	0
93.00	All other Medical Education	0	40,846,108	0.000000	4,869,157	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Component CCN: 14T116		Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,668	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,668	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,668	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)		4,802	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,299,007	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)		6,299,007	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,299,007	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		944.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,536,257	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)		4,536,257	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Component CCN: 14T116				Date/Time Prepared: 11/22/2016 12:45 pm	
		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)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,256,836		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,793,093		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)					312,562		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					126,241		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					438,803		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,354,290		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: 140116 Component CCN: 14T116		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/22/2016 12:45 pm	
		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	434,007	6,299,007	0.068901	0	0	90.00
91.00	Nursing School cost	0	6,299,007	0.000000	0	0	91.00
92.00	Allied health cost	0	6,299,007	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,299,007	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/22/2016 12:45 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		31,589,619	30.00
31.00	03100	INTENSIVE CARE UNIT		7,030,073	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.233685	15,226,733	50.00
51.00	05100	RECOVERY ROOM	0.202946	2,163,151	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.583831	0	52.00
53.00	05300	ANESTHESIOLOGY	0.071856	1,995,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144665	7,583,429	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.198515	500,065	55.00
56.00	05600	RADIOISOTOPE	0.132922	1,127,561	56.00
57.00	05700	CT SCAN	0.033547	8,996,286	57.00
58.00	05800	MRI	0.055436	1,268,587	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.153499	7,232,062	59.00
60.00	06000	LABORATORY	0.106481	18,672,457	60.00
65.00	06500	RESPIRATORY THERAPY	0.276277	4,734,277	65.00
66.00	06600	PHYSICAL THERAPY	0.270552	2,671,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288632	1,449,360	67.00
68.00	06800	SPEECH PATHOLOGY	0.239724	890,742	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.259619	74,900	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.512653	5,148,641	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.451300	13,188,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.323095	16,673,278	73.00
76.00	03140	CARDIOLOGY	0.221537	369,068	76.00
76.97	07697	CARDIAC REHABILITATION	0.513445	70,276	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.768413	11,716	90.00
90.01	09001	DIABETES CENTER	0.652648	0	90.01
91.00	09100	EMERGENCY	0.172041	9,046,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.752988	0	92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.278018	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		119,094,980	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)		119,094,980	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3	
		Component CCN: 14T116		Date/Time Prepared: 11/22/2016 12:45 pm	
		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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		6,420,974		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.233685	0	0	50.00
51.00	05100 RECOVERY ROOM	0.202946	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.583831	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.071856	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.144665	139,243	20,144	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.198515	64,214	12,747	55.00
56.00	05600 RADIOISOTOPE	0.132922	0	0	56.00
57.00	05700 CT SCAN	0.033547	105,500	3,539	57.00
58.00	05800 MRI	0.055436	23,272	1,290	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.153499	0	0	59.00
60.00	06000 LABORATORY	0.106481	1,042,961	111,056	60.00
65.00	06500 RESPIRATORY THERAPY	0.276277	178,383	49,283	65.00
66.00	06600 PHYSICAL THERAPY	0.270552	2,377,770	643,310	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.288632	2,285,214	659,586	67.00
68.00	06800 SPEECH PATHOLOGY	0.239724	1,752,690	420,162	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.259619	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.512653	10,237	5,248	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.451300	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.323095	1,021,750	330,122	73.00
76.00	03140 RADIOLOGY	0.221537	1,577	349	76.00
76.97	07697 CARDIAC REHABILITATION	0.513445	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.768413	0	0	90.00
90.01	09001 DIABETES CENTER	0.652648	0	0	90.01
91.00	09100 EMERGENCY	0.172041	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.752988	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.278018	0	0	97.00
200.00	Total (sum of lines 50-94 and 96-98)		9,002,811	2,256,836	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)		9,002,811		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		8,814,773	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		29,685,628	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)		837,107	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)		145.58	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.22	30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.25	31.00
32.00	Sum of lines 30 and 31		18.47	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.76	33.00
34.00	Disproportionate share adjustment (see instructions)		458,155	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000122682	0.000121477	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	938,228	778,199	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	236,485	582,586	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	819,071		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
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)	40,614,734		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		40,614,734	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,262,984	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)		43,877,718	59.00
60.00	Primary payer payments		9,738	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		43,867,980	61.00
62.00	Deductibles billed to program beneficiaries		3,891,076	62.00
63.00	Coinurance billed to program beneficiaries		122,143	63.00
64.00	Allowable bad debts (see instructions)		577,387	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		375,302	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		359,409	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		40,230,063	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		126,677	70.93
70.94	HRR adjustment amount (see instructions)		-224,325	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 12:45 pm	
		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	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	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)			40,132,415	71.00
71.01	Sequestration adjustment (see instructions)			802,648	71.01
72.00	Interim payments			38,472,859	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)			856,908	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			25,025	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 11/22/2016 12:45 pm	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	1.22	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	17.25	0.00			17.25	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	18.47	0.00			17.25	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	145.58	0.00			145.58	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	4.76	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)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	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)	1.22	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)	0.81	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,219	0			1,219	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	873	0			873	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)	3	0			3	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	4,510	0			4,510	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	206	0			206	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	6,811	0			6,811	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	38,956	0			38,956	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	539	0			539	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)	39,495	0			39,495	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	17.25	0.00			17.25	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140116		Period: From 07/01/2015 To 06/30/2016		Worksheet DSH Date/Time Prepared: 11/22/2016 12:45 pm	
		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	
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	False	0.00		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	True	4.76		0.00	True	29.00
30.00	Line 28 or 29 as applicable		4.76		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.		0.00		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	
DETERMINATION OF PROVIDER TYPE							
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-)	False				False	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)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet DSH Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	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	3.96	29.00
30.00	Line 28 or 29 as applicable	3.96	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/22/2016 12:45 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,814,773	0	8,814,773		8,814,773	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	29,685,628	0		29,685,628	29,685,628	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	837,107	0	127,707	709,400	837,107	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0476	0.0476	0.0476	0.0476		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	458,155	0	104,896	353,259	458,155	11.00
11.01	Uncompensated care payments	36.00	819,071	0	819,071	0	819,071	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	40,614,734	0	9,866,447	30,748,287	40,614,734	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	40,614,734	0	9,866,447	30,748,287	40,614,734	15.00
16.00	Payment for inpatient program capital	50.00	3,262,984	0	742,094	2,520,890	3,262,984	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/22/2016 12:45 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	10,608,541	33,269,177	43,877,718	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	3,085,948	0	704,738	2,381,210	3,085,948	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	59,461	0	10,505	48,956	59,461	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0381	0.0381	0.0381	0.0381		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	117,575	0	26,851	90,724	117,575	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,262,984	0	742,094	2,520,890	3,262,984	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/22/2016 12:45 pm
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		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,814,773	8,814,773		8,814,773	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	29,685,628		29,685,628	29,685,628	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	837,107	127,707	709,400	837,107	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0476	0.0476	0.0476		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	458,155	104,896	353,259	458,155	11.00
11.01	Uncompensated care payments	36.00	819,071	236,485	0	236,485	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	40,614,734	9,283,861	31,330,873	40,614,734	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	40,614,734	9,283,861	31,330,873	40,614,734	15.00
16.00	Payment for inpatient program capital	50.00	3,262,984	742,094	2,520,890	3,262,984	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,025,955	33,851,763	43,877,718	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/22/2016 12:45 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	3,085,948	704,738	2,381,210	3,085,948	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	59,461	10,505	48,956	59,461	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0381	0.0381	0.0381		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	117,575	26,851	90,724	117,575	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,262,984	742,094	2,520,890	3,262,984	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	126,677	4,578	122,099	126,677	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-224,325	-66,992	-157,333	-224,325	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		212,986	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		39,070,639	2.00
3.00	PPS payments		29,298,929	3.00
4.00	Outlier payment (see instructions)		32,237	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		212,986	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		651,185	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)		651,185	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		651,185	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		438,199	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)		212,986	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)		29,331,166	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		38	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		6,160,396	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)		23,383,718	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)		23,383,718	30.00
31.00	Primary payer payments		4,016	31.00
32.00	Subtotal (line 30 minus line 31)		23,379,702	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		747,949	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		486,167	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		555,825	36.00
37.00	Subtotal (see instructions)		23,865,869	37.00
38.00	MSP-LCC reconciliation amount from PS&R		328	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)		23,865,541	40.00
40.01	Sequestration adjustment (see instructions)		477,311	40.01
41.00	Interim payments		23,234,255	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		153,975	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 12:45 pm
		Component CCN: 14T116	Title XVII	Subprovider - IRF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		223	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		211	2.00
3.00	PPS payments		220	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		223	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		691	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)		691	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		691	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		468	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)		223	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)		220	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		443	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)		443	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		443	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		443	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)		443	40.00
40.01	Sequestration adjustment (see instructions)		9	40.01
41.00	Interim payments		405	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		29	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
		Overrides		
		1.00		
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2016 12:45 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		38,289,530		23,217,350	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	01/28/2016	183,329	01/28/2016	16,905	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)		183,329		16,905	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)		38,472,859		23,234,255	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		856,908		153,975	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		39,329,767		23,388,230	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: 140116
Component CCN: 14T116

Period:
From 07/01/2015
To 06/30/2016

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2016 12:45 pm
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		6,464,040		405	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	01/28/2016	4,810		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)		4,810		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)		6,468,850		405	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		36,562		29	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,505,412		434	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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		9,325	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		18,109	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		2,257	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		35,179	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		908,472,055	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		8,112,463	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)		1,061,660	8.00
9.00	Sequestration adjustment amount (see instructions)		21,233	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1,040,427	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		1,072,852	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)		-32,425	32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140116 Component CCN: 14T116	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part III Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			6,512,822 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0081 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			104,856 3.00
4.00	Outlier Payments			70,375 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			18.218579 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)			6,688,053 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)			6,688,053 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			6,688,053 19.00
20.00	Deductibles			15,372 20.00
21.00	Subtotal (line 19 minus line 20)			6,672,681 21.00
22.00	Coinsurance			37,723 22.00
23.00	Subtotal (line 21 minus line 22)			6,634,958 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			4,950 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			3,218 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,766 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,638,176 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)			6,638,176 32.00
32.01	Sequestration adjustment (see instructions)			132,764 32.01
33.00	Interim payments			6,468,850 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)			36,562 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			98,995 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			70,375 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: 140116 Period: From 07/01/2015 To 06/30/2016 Worksheet G
 Date/Time Prepared: 11/22/2016 12:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	194,000	0	0	0	1.00
2.00	Temporary investments	54,487,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	51,493,000	0	0	0	4.00
5.00	Other receivable	21,984,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	5,815,000	0	0	0	7.00
8.00	Prepaid expenses	1,451,000	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)	135,424,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	1,764,249	0	0	0	13.00
14.00	Accumulated depreciation	-1,697,953	0	0	0	14.00
15.00	Buildings	256,755,588	0	0	0	15.00
16.00	Accumulated depreciation	-45,536,537	0	0	0	16.00
17.00	Leasehold improvements	551,252	0	0	0	17.00
18.00	Accumulated depreciation	-91,986	0	0	0	18.00
19.00	Fixed equipment	12,588,902	0	0	0	19.00
20.00	Accumulated depreciation	-12,584,243	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	124,737,614	0	0	0	23.00
24.00	Accumulated depreciation	-91,770,459	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	9,336,651	0	0	0	27.00
28.00	Accumulated depreciation	-4,432,078	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	249,686,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	76,987,000	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	8,336,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	85,323,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	470,433,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,268,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	16,967,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	16,754,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	37,989,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	250,123,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,168,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	253,291,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	291,280,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	179,153,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	179,153,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	470,433,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-1

Date/Time Prepared:
11/22/2016 12:45 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		173,201,000			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		15,860,000				2.00
3.00	Total (sum of line 1 and line 2)		189,061,000			0	3.00
4.00	UNRESTRICTED NET ASSETS RELEASED	1,977,000		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,977,000			0	10.00
11.00	Subtotal (line 3 plus line 10)		191,038,000			0	11.00
12.00	CHANGES IN TEMP RESTRICTED ASSETS	464,000		0		0	12.00
13.00	CHANGES IN UNREALIZED LOSSES	2,513,000		0		0	13.00
14.00	TRANSFER TO AFFILIATED ORGANIZATION	8,908,000		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)		11,885,000			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		179,153,000			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	UNRESTRICTED NET ASSETS RELEASED		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGES IN TEMP RESTRICTED ASSETS		0				12.00
13.00	CHANGES IN UNREALIZED LOSSES		0				13.00
14.00	TRANSFER TO AFFILIATED ORGANIZATION		0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/22/2016 12:45 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	63,219,811		63,219,811	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	8,865,582		8,865,582	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)	72,085,393		72,085,393	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,946,587		12,946,587	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)	12,946,587		12,946,587	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	85,031,980		85,031,980	17.00
18.00	Ancillary services	235,375,236	471,357,425	706,732,661	18.00
19.00	Outpatient services	16,373,847	90,116,790	106,490,637	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		6,179,600	6,179,600	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	DME	0	4,037,177	4,037,177	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	336,781,063	571,690,992	908,472,055	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		286,507,063		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)		286,507,063		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140116

Period:
From 07/01/2015
To 06/30/2016

Worksheet G-3

Date/Time Prepared:
11/22/2016 12:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	908,472,055	1.00
2.00	Less contractual allowances and discounts on patients' accounts	612,978,055	2.00
3.00	Net patient revenues (line 1 minus line 2)	295,494,000	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	286,507,063	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,986,937	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	-311,203	6.00
7.00	Income from investments	435,101	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	6,748,491	24.00
24.01	ROUNDING	674	24.01
25.00	Total other income (sum of lines 6-24)	6,873,063	25.00
26.00	Total (line 5 plus line 25)	15,860,000	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,860,000	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140116

Period: From 07/01/2015

Worksheet H

HHA CCN: 147455

To 06/30/2016

Date/Time Prepared: 11/22/2016 12:45 pm

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	732,399	0	0	0	176,307	908,706	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,070,835	0	70,875	0	0	1,141,710	6.00
7.00	Physical Therapy	854,548	0	54,952	0	0	909,500	7.00
8.00	Occupational Therapy	95,719	0	6,345	0	0	102,064	8.00
9.00	Speech Pathology	48,711	0	3,229	0	0	51,940	9.00
10.00	Medical Social Services	43,204	0	486	0	0	43,690	10.00
11.00	Home Health Aide	98,376	0	9,323	0	0	107,699	11.00
12.00	Supplies (see instructions)	0	0	0	0	132,202	132,202	12.00
13.00	Drugs	0	0	0	0	3,702	3,702	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,943,792	0	145,210	0	312,211	3,401,213	24.00
		Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	45,203	953,909	-28,894	925,015			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	1,141,710	0	1,141,710			6.00
7.00	Physical Therapy	0	909,500	0	909,500			7.00
8.00	Occupational Therapy	0	102,064	0	102,064			8.00
9.00	Speech Pathology	0	51,940	0	51,940			9.00
10.00	Medical Social Services	0	43,690	0	43,690			10.00
11.00	Home Health Aide	0	107,699	0	107,699			11.00
12.00	Supplies (see instructions)	0	132,202	0	132,202			12.00
13.00	Drugs	0	3,702	0	3,702			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	45,203	3,446,416	-28,894	3,417,522			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet H-1 Part I Date/Time Prepared: 11/22/2016 12:45 pm
		HHA CCN: 147455	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bl dgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	925,015	0	0	0	925,015	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,141,710	0	0	0	1,141,710	6.00
7.00	Physical Therapy	909,500	0	0	0	909,500	7.00
8.00	Occupational Therapy	102,064	0	0	0	102,064	8.00
9.00	Speech Pathology	51,940	0	0	0	51,940	9.00
10.00	Medical Social Services	43,690	0	0	0	43,690	10.00
11.00	Home Health Aide	107,699	0	0	0	107,699	11.00
12.00	Supplies (see instructions)	132,202	0	0	0	132,202	12.00
13.00	Drugs	3,702	0	0	0	3,702	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,417,522	0	0	0	3,417,522	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	925,015					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	423,709	1,565,419				6.00
7.00	Physical Therapy	337,532	1,247,032				7.00
8.00	Occupational Therapy	37,878	139,942				8.00
9.00	Speech Pathology	19,276	71,216				9.00
10.00	Medical Social Services	16,214	59,904				10.00
11.00	Home Health Aide	39,969	147,668				11.00
12.00	Supplies (see instructions)	49,063	181,265				12.00
13.00	Drugs	1,374	5,076				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		3,417,522				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140116
HHA CCN: 147455

Period:
From 07/01/2015
To 06/30/2016

Worksheet H-1
Part II
Date/Time Prepared:
11/22/2016 12:45 pm
PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-925,015	2,492,507
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,141,710
7.00	Physical Therapy	0	0	0	0	0	909,500
8.00	Occupational Therapy	0	0	0	0	0	102,064
9.00	Speech Pathology	0	0	0	0	0	51,940
10.00	Medical Social Services	0	0	0	0	0	43,690
11.00	Home Health Aide	0	0	0	0	0	107,699
12.00	Supplies (see instructions)	0	0	0	0	0	132,202
13.00	Drugs	0	0	0	0	0	3,702
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-925,015	2,492,507
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		925,015
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.371118

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140116

Period: From 07/01/2015

Worksheet H-2

HHA CCN: 147455

To 06/30/2016

Part I Date/Time Prepared: 11/22/2016 12:45 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	0	0	781,078	781,078	178,576	1.00
2.00 Skilled Nursing Care	1,565,419	0	0	0	1,565,419	357,895	2.00
3.00 Physical Therapy	1,247,032	0	0	0	1,247,032	285,105	3.00
4.00 Occupational Therapy	139,942	0	0	0	139,942	31,995	4.00
5.00 Speech Pathology	71,216	0	0	0	71,216	16,282	5.00
6.00 Medical Social Services	59,904	0	0	0	59,904	13,696	6.00
7.00 Home Health Aide	147,668	0	0	0	147,668	33,761	7.00
8.00 Supplies (see instructions)	181,265	0	0	0	181,265	41,442	8.00
9.00 Drugs	5,076	0	0	0	5,076	1,161	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	3,417,522	0	0	781,078	4,198,600	959,913	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	0	0	0	0	43,083	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	43,083	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140116

Period: From 07/01/2015

Worksheet H-2 Part I

HHA CCN: 147455

To 06/30/2016

Date/Time Prepared: 11/22/2016 12:45 pm

Home Health Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	17.00	24.00	25.00	
1.00	Administrative and General	0	0	32,517	0	1,035,254	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	1,923,314	0	2.00
3.00	Physical Therapy	0	0	0	0	1,532,137	0	3.00
4.00	Occupational Therapy	0	0	0	0	171,937	0	4.00
5.00	Speech Pathology	0	0	0	0	87,498	0	5.00
6.00	Medical Social Services	0	0	0	0	73,600	0	6.00
7.00	Home Health Aide	0	0	0	0	181,429	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	222,707	0	8.00
9.00	Drugs	0	0	0	0	6,237	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	32,517	0	5,234,113	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	1,035,254						1.00
2.00	Skilled Nursing Care	1,923,314	474,204	2,397,518				2.00
3.00	Physical Therapy	1,532,137	377,758	1,909,895				3.00
4.00	Occupational Therapy	171,937	42,392	214,329				4.00
5.00	Speech Pathology	87,498	21,573	109,071				5.00
6.00	Medical Social Services	73,600	18,147	91,747				6.00
7.00	Home Health Aide	181,429	44,732	226,161				7.00
8.00	Supplies (see instructions)	222,707	54,910	277,617				8.00
9.00	Drugs	6,237	1,538	7,775				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	5,234,113	1,035,254	5,234,113				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.246556					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140116
HHA CCN: 147455

Period: From 07/01/2015 To 06/30/2016

Worksheet H-2
Part II
Date/Time Prepared: 11/22/2016 12:45 pm
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	0	0	2,988,995	0	781,078	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	1,565,419	0	2.00
3.00 Physical Therapy	0	0	0	0	1,247,032	0	3.00
4.00 Occupational Therapy	0	0	0	0	139,942	0	4.00
5.00 Speech Pathology	0	0	0	0	71,216	0	5.00
6.00 Medical Social Services	0	0	0	0	59,904	0	6.00
7.00 Home Health Aide	0	0	0	0	147,668	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	181,265	0	8.00
9.00 Drugs	0	0	0	0	5,076	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	2,988,995		4,198,600	0	20.00
21.00 Total cost to be allocated	0	0	781,078		959,913	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.261318		0.228627	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	0	0	4,051	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	4,051	0	0	20.00
21.00 Total cost to be allocated	0	0	0	43,083	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	10.635152	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140116
HHA CCN: 147455

Period:
From 07/01/2015
To 06/30/2016

Worksheet H-2
Part II
Date/Time Prepared:
11/22/2016 12:45 pm
PPS

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)		
	15.00	16.00	17.00		
1.00 Administrative and General	0	6,179,600	0		1.00
2.00 Skilled Nursing Care	0	0	0		2.00
3.00 Physical Therapy	0	0	0		3.00
4.00 Occupational Therapy	0	0	0		4.00
5.00 Speech Pathology	0	0	0		5.00
6.00 Medical Social Services	0	0	0		6.00
7.00 Home Health Aide	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0		8.00
9.00 Drugs	0	0	0		9.00
10.00 DME	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0		13.00
14.00 Clinic	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0		15.00
16.00 Day Care Program	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0		17.00
18.00 Homemaker Service	0	0	0		18.00
19.00 All Others (specify)	0	0	0		19.00
20.00 Total (sum of lines 1-19)	0	6,179,600	0		20.00
21.00 Total cost to be allocated	0	32,517	0		21.00
22.00 Unit cost multiplier	0.000000	0.005262	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part I Date/Time Prepared: 11/22/2016 12:45 pm
			HHA CCN: 147455	Title XVIII	Home Health Agency I

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	2,397,518		2,397,518	14,444	165.99	1.00
2.00	Physical Therapy	3.00	1,909,895	0	1,909,895	11,199	170.54	2.00
3.00	Occupational Therapy	4.00	214,329	0	214,329	1,293	165.76	3.00
4.00	Speech Pathology	5.00	109,071	0	109,071	658	165.76	4.00
5.00	Medical Social Services	6.00	91,747		91,747	99	926.74	5.00
6.00	Home Health Aide	7.00	226,161		226,161	1,900	119.03	6.00
7.00	Total (sum of lines 1-6)		4,948,721	0	4,948,721	29,593		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	0	8,941		8.00
8.01	Skilled Nursing Care		29404	0	620		8.01
9.00	Physical Therapy		16974	0	6,309		9.00
9.01	Physical Therapy		29404	0	512		9.01
10.00	Occupational Therapy		16974	0	751		10.00
10.01	Occupational Therapy		29404	0	76		10.01
11.00	Speech Pathology		16974	0	417		11.00
11.01	Speech Pathology		29404	0	53		11.01
12.00	Medical Social Services		16974	0	49		12.00
12.01	Medical Social Services		29404	0	10		12.01
13.00	Home Health Aide		16974	0	1,668		13.00
13.01	Home Health Aide		29404	0	113		13.01
14.00	Total (sum of lines 8-13)			0	19,519		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	277,617	0	277,617	311,021	0.892599	15.00
16.00	Cost of Drugs	9.00	7,775	0	7,775	0	0.000000	16.00
Cost Center Description	Part A	Program Visits		Part A	Cost of Services	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00		

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	9,561		0	1,587,030	1.00
2.00	Physical Therapy	0	6,821		0	1,163,253	2.00
3.00	Occupational Therapy	0	827		0	137,084	3.00
4.00	Speech Pathology	0	470		0	77,907	4.00
5.00	Medical Social Services	0	59		0	54,678	5.00
6.00	Home Health Aide	0	1,781		0	211,992	6.00
7.00	Total (sum of lines 1-6)	0	19,519		0	3,231,944	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140116
HHA CCN: 147455

Period:
From 07/01/2015
To 06/30/2016

Worksheet H-3
Part I
Date/Time Prepared:
11/22/2016 12:45 pm
PPS

Title XVII I

Home Health Agency I

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		2,781	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	1,587,030						1.00
2.00	Physical Therapy	1,163,253						2.00
3.00	Occupational Therapy	137,084						3.00
4.00	Speech Pathology	77,907						4.00
5.00	Medical Social Services	54,678						5.00
6.00	Home Health Aide	211,992						6.00
7.00	Total (sum of lines 1-6)	3,231,944						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140116 HHA CCN: 147455	Period: From 07/01/2015 To 06/30/2016	Worksheet H-3 Part II Date/Time Prepared: 11/22/2016 12:45 pm PPS
		Title XVIII	Home Health Agency I	

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.270225	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.288632	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.239724	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.512653	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.323095	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140116 HHA CCN: 147455	Period: From 07/01/2015 To 06/30/2016	Worksheet H-4 Part I-11 Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	2,781	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	2,781	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	2,781	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	3,646,441
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	63,483
13.00	Total PPS Reimbursement - LUPA Episodes		0	62,656
14.00	Total PPS Reimbursement - PEP Episodes		0	12,305
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	34,440
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	4,642
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	3,823,967
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	3,823,967
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	3,823,967
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	3,823,967
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	3,823,967
31.01	Sequestration adjustment (see instructions)		0	76,463
32.00	Interim payments (see instructions)		0	3,749,398
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-1,894
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140116
HHA CCN: 147455

Period:
From 07/01/2015
To 06/30/2016

Worksheet H-5
Date/Time Prepared:
11/22/2016 12:45 pm
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		0		3,749,398	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			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			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. H-4, Part II, column as appropriate, line 32)		0		3,749,398	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,894	6.02
7.00	Total Medicare program liability (see instructions)		0		3,747,504	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140116	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/22/2016 12:45 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,085,948	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		59,461	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)		97.59	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)		1.22	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		17.25	8.00
9.00	Sum of lines 7 and 8		18.47	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.81	10.00
11.00	Disproportionate share adjustment (see instructions)		117,575	11.00
12.00	Total prospective capital payments (see instructions)		3,262,984	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00