

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: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S Parts I-III Date/Time Prepared: 8/29/2016 8:13 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 8/29/2016 Time: 8:13 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL OF CARBONDALE ( 140164 ) for the cost reporting period beginning 04/01/2015 and ending 03/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-240,851	-237,288	859	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		14,881		0	10.00
200.00 Total	0	-240,851	-222,407	859	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: 140164		Period: From 04/01/2015 To 03/31/2016		Worksheet S-2 Part I Date/Time Prepared: 8/29/2016 8:10 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 62901 County: JACKSON				
1.00 Street: 405 W. JACKSON STREET		2.00 City: CARBONDALE								
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	MEMORIAL HOSPITAL OF CARBONDALE	140164	16010	1	07/01/1966	N	P	O	
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC	WEST FRANKFORT FAMILY MEDICINE	143454	99914		11/01/1999	N	O	N	
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					04/01/2015	03/31/2016		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (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)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an 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.	8,178	1,537	0	0	345	1,055		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part I Date/Time Prepared: 8/29/2016 8:10 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			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	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		
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			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.	N			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)				Y	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)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	9.77	4.69	0.675657	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)	SOUTHERN ILLINOIS FAMILY MEDICINE	1350	9.20	7.11	0.564071
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
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.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V 1.00	XIX 2.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					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
					1.00
					2.00
					3.00
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,953,616	0		0
					1.00
					2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		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
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part I Date/Time Prepared: 8/29/2016 8:10 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	14H124			140.00
		1.00	2.00	3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: SO ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 06101		141.00
142.00	Street: 1239 E. MAIN STREET	PO Box: 3988				142.00
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988		143.00
						1.00
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00
				1.00		
				2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00
		Part A		Part B		Title V
		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	161.00
				1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00
		Name		County		State
		0		1.00		2.00
						3.00
						4.00
						5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y			167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part I Date/Time Prepared: 8/29/2016 8:10 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)		07/01/2015	09/28/2015	170.00
				1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part II Date/Time Prepared: 8/29/2016 8:10 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.	Y			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/13/2016	Y	07/13/2016
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part II Date/Time Prepared: 8/29/2016 8:10 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN		41.00
42.00	Enter the employer/company name of the cost report preparer.	SIH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6184575200	LUANNE.WARREN@SIH.NET		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140164

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
8/29/2016 8:10 pm

		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-2 Part IX Date/Time Prepared: 8/29/2016 8:10 pm	
			Title V	Title XIX	
			1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
<b>RCE DISALLOWANCE</b>					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	6.00
<b>PASS THROUGH COST</b>					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	7.00
<b>RHC</b>					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140164

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 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	13	4,758	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 NEONATAL INTENSIVE CARE UNIT	35.00	13	4,758	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		159	58,194	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		159				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)		9	3,294			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: 140164

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 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)	13,256	5,719	29,730			1.00
2.00 HMO and other (see instructions)	2,431	1,400				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	13,256	5,719	29,730			7.00
8.00 INTENSIVE CARE UNIT	2,026	530	3,849			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 NEONATAL INTENSIVE CARE UNIT	0	1,220	1,751			12.00
13.00 NURSERY		1,550	3,059			13.00
14.00 Total (see instructions)	15,282	9,019	38,389	13.26	1,127.05	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	2,961	3,323	10,632	3.05	12.41	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				16.31	1,139.46	27.00
28.00 Observation Bed Days		973	4,029			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	696	1,551			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			652			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140164

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 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	4,086	2,707	10,877	1.00
2.00 HMO and other (see instructions)			700	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	4,086	2,707	10,877	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					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: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-3 Part II Date/Time Prepared: 8/29/2016 8:10 pm			
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	63,410,571	0	63,410,571	2,410,622.93	26.30	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		602,118	0	602,118	29,536.81	20.39	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	1,083,107	0	1,083,107	40,538.83	26.72	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		703,097	0	703,097	12,572.50	55.92	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		370,598	0	370,598	2,249.00	164.78	13.00
14.00	Home office salaries & wage-related costs		13,546,584	0	13,546,584	312,050.97	43.41	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		16,750,218	0	16,750,218			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		163,395	0	163,395			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		293,919	0	293,919			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	264,047	0	264,047	0.00	0.00	26.00
27.00	Administrative & General	5.00	6,083,587	0	6,083,587	200,396.78	30.36	27.00
28.00	Administrative & General under contract (see inst.)		671,058	0	671,058	2,035.12	329.74	28.00
29.00	Maintenance & Repairs	6.00	656,560	0	656,560	29,713.15	22.10	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	37,368	0	37,368	3,493.49	10.70	31.00
32.00	Housekeeping	9.00	1,184,750	0	1,184,750	99,299.47	11.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,431,037	-1,061,948	369,089	24,596.66	15.01	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,061,948	1,061,948	73,946.45	14.36	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,090,785	0	1,090,785	28,519.90	38.25	38.00
39.00	Central Services and Supply	14.00	281,721	0	281,721	22,425.35	12.56	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140164

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
8/29/2016 8:10 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hou rs Rel ated to Sal ari es i n col . 4	Average Hou rly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 521,420	0	521,420	33,742.33	15.45	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140164

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
8/29/2016 8:10 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	62,396,404	0	62,396,404	2,342,582.41	26.64	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	62,396,404	0	62,396,404	2,342,582.41	26.64	3.00
4.00	Subtotal other wages & related costs (see inst.)	14,620,279	0	14,620,279	326,872.47	44.73	4.00
5.00	Subtotal wage-related costs (see inst.)	16,750,218	0	16,750,218	0.00	26.84	5.00
6.00	Total (sum of lines 3 thru 5)	93,766,901	0	93,766,901	2,669,454.88	35.13	6.00
7.00	Total overhead cost (see instructions)	12,222,333	0	12,222,333	518,168.70	23.59	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-3 Part IV Date/Time Prepared: 8/29/2016 8:10 pm
			Amount Reported	
			1.00	
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		250	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		9,971,853	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		151,350	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		28,882	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)		173,509	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		763,776	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		1,254,849	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		4,606,657	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		69,565	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		186,841	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		17,207,532	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-3 Part V Date/Time Prepared: 8/29/2016 8:10 pm
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Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	703,097	16,750,218	1.00
2.00	Hospital	703,097	16,750,218	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2015 To 03/31/2016	Worksheet S-8 Date/Time Prepared: 8/29/2016 8:10 pm	
			Rural Health Clinic (RHC) I	Cost	
				1.00	
1.00	Clinic Address and Identification Street		2553 KEN GRAY BLVD	1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		WEST FRANKFORT IL	62896 2.00	
				1.00	
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00	
			Grant Award	Date	
			1.00	2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0 4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			0 5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0 6.00	
7.00	Appalachian Regional Commission			0 7.00	
8.00	Look-Alikes			0 8.00	
9.00	OTHER (SPECIFY)			0 9.00	
				1.00 2.00	
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N 0 10.00	
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00 11.00
				1.00 2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N 12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N 0 13.00	
			Provider name	CCN number	
			1.00	2.00	
14.00	Provider name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits			5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
			County		
			4.00		
2.00	City, State, ZIP Code, County		FRANKLINE		2.00
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
		17:00		17:00	
11.00	Facility hours of operations (1) Clinic		17:00	08:00	17:00 11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2015 To 03/31/2016	Worksheet S-8 Date/Time Prepared: 8/29/2016 8:10 pm	
			Rural Health Clinic (RHC) I	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet S-10 Date/Time Prepared: 8/29/2016 8:10 pm
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			1.00			
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.256522	1.00		
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid		21,460,622	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		10,766,795	5.00		
6.00	Medicaid charges		169,399,487	6.00		
7.00	Medicaid cost (line 1 times line 6)		43,454,695	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)		11,227,278	8.00		
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>						
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		
<b>Other state or local government indigent care program (see instructions for each line)</b>						
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		
<b>Uncompensated care (see instructions for each line)</b>						
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		325,068	18.00		
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		11,227,278	19.00		
			Uninsured patients	Insured patients		
			1.00	2.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		6,494,781	2,694,749	9,189,530	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		1,666,054	691,262	2,357,316	21.00
22.00	Partial payment by patients approved for charity care		0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		1,666,054	691,262	2,357,316	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?					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)				11,082,133	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				1,314,750	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)				9,767,383	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				2,505,549	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				4,862,865	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				16,090,143	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140164

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

Worksheet A  
Date/Time Prepared: 8/29/2016 8:10 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		5,491,209	5,491,209	304,720	5,795,929	1.00
2.00	00200		5,811,469	5,811,469	137,253	5,948,722	2.00
4.00	00400	264,047	21,903,962	22,168,009	0	22,168,009	4.00
5.01	00550	0	0	0	0	0	5.01
5.02	00560	220,758	129,846	350,604	0	350,604	5.02
5.03	00580	649,422	62,280	711,702	0	711,702	5.03
5.04	00590	5,213,407	19,811,895	25,025,302	-30,370	24,994,932	5.04
6.00	00600	656,560	1,088,337	1,744,897	0	1,744,897	6.00
8.00	00800	37,368	1,343,171	1,380,539	0	1,380,539	8.00
9.00	00900	1,184,750	380,133	1,564,883	0	1,564,883	9.00
10.00	01000	1,431,037	1,273,193	2,704,230	-2,022,159	682,071	10.00
11.00	01100	0	0	0	2,006,762	2,006,762	11.00
13.00	01300	1,090,785	40,184	1,130,969	-304	1,130,665	13.00
14.00	01400	281,721	130,452	412,173	-23,056	389,117	14.00
16.00	01600	521,420	81,920	603,340	0	603,340	16.00
19.00	01900	0	0	0	3,083,276	3,083,276	19.00
21.00	02100	1,083,107	0	1,083,107	0	1,083,107	21.00
22.00	02200	0	1,186,670	1,186,670	0	1,186,670	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	14,170,162	6,589,165	20,759,327	-75,867	20,683,460	30.00
31.00	03100	2,870,103	675,351	3,545,454	-52,480	3,492,974	31.00
35.00	02060	948,279	625,910	1,574,189	-271	1,573,918	35.00
43.00	04300	3,433	192,958	196,391	-18,457	177,934	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,605,908	18,134,176	21,740,084	-11,498,681	10,241,403	50.00
50.01	05001	1,342,814	660,246	2,003,060	-2,003,060	0	50.01
51.00	05100	712,877	37,486	750,363	-3,431	746,932	51.00
52.00	05200	3,786,559	456,144	4,242,703	-38,498	4,204,205	52.00
53.00	05300	414,120	3,806,194	4,220,314	-3,255,793	964,521	53.00
54.00	05400	2,789,000	2,102,150	4,891,150	-871,851	4,019,299	54.00
54.01	03480	918,266	2,020,083	2,938,349	13,958	2,952,307	54.01
54.02	03440	637,907	674,267	1,312,174	-4,275	1,307,899	54.02
56.00	05600	259,055	1,144,158	1,403,213	177,272	1,580,485	56.00
58.00	05800	244,757	219,438	464,195	-60,141	404,054	58.00
59.00	05900	3,909,942	16,249,773	20,159,715	-11,965,119	8,194,596	59.00
60.00	06000	2,274,948	4,642,030	6,916,978	-46,965	6,870,013	60.00
64.00	06400	319,132	191,057	510,189	-13,477	496,712	64.00
65.00	06500	1,232,392	321,649	1,554,041	-111,314	1,442,727	65.00
66.00	06600	2,204,395	721,291	2,925,686	-657	2,925,029	66.00
69.00	06900	1,256,232	7,235,483	8,491,715	-475,094	8,016,621	69.00
70.00	07000	83,339	54,056	137,395	-3,456	133,939	70.00
71.00	07100	0	0	0	21,646,329	21,646,329	71.00
72.00	07200	0	0	0	4,949,727	4,949,727	72.00
73.00	07300	2,868,081	12,949,656	15,817,737	744,797	16,562,534	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	382,951	1,063,889	1,446,840	-15,170	1,431,670	88.00
91.00	09100	3,541,537	4,050,051	7,591,588	-32,175	7,559,413	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300		4,118,787	4,118,787	-441,973	3,676,814	113.00
118.00		63,410,571	147,670,169	211,080,740	0	211,080,740	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	108,648	108,648	0	108,648	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
200.00		63,410,571	147,778,817	211,189,388	0	211,189,388	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140164

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

Worksheet A  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-326,295	5,469,634	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,666,172	11,614,894	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	520,927	22,688,936	4.00
5.01	00550	DATA PROCESSING	7,203,010	7,203,010	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-12,711	337,893	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,580,002	4,291,704	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	2,701,227	27,696,159	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	1,744,897	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,380,539	8.00
9.00	00900	HOUSEKEEPING	-131	1,564,752	9.00
10.00	01000	DIETARY	0	682,071	10.00
11.00	01100	CAFETERIA	-1,180,277	826,485	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,130,665	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	389,117	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-116,392	486,948	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-3,083,276	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,083,107	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	-911	1,185,759	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-3,371,504	17,311,956	30.00
31.00	03100	INTENSIVE CARE UNIT	-10,647	3,482,327	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	-563,928	1,009,990	35.00
43.00	04300	NURSERY	0	177,934	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-364,246	9,877,157	50.00
50.01	05001	SAME DAY SURGERY	0	0	50.01
51.00	05100	RECOVERY ROOM	0	746,932	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,024	4,203,181	52.00
53.00	05300	ANESTHESIOLOGY	0	964,521	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,002	4,008,297	54.00
54.01	03480	ONCOLOGY	-1,086,399	1,865,908	54.01
54.02	03440	MAMMOGRAPHY	-46,615	1,261,284	54.02
56.00	05600	RADIOISOTOPE	0	1,580,485	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	404,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	-61,349	8,133,247	59.00
60.00	06000	LABORATORY	-134,241	6,735,772	60.00
64.00	06400	INTRAVENOUS THERAPY	-10,259	486,453	64.00
65.00	06500	RESPIRATORY THERAPY	-2,097	1,440,630	65.00
66.00	06600	PHYSICAL THERAPY	-68,475	2,856,554	66.00
69.00	06900	ELECTROCARDIOLOGY	-223,950	7,792,671	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-8,552	125,387	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21,646,329	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	4,949,727	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,562,534	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-59,327	1,372,343	88.00
91.00	09100	EMERGENCY	-3,286,994	4,272,419	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	-3,676,814	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,963,922	213,044,662	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	108,648	192.00
192.01	19201	FAMILY PRACTICE	0	0	192.01
192.02	19202	UNUSED SPACE	0	0	192.02
200.00		TOTAL (SUM OF LINES 118-199)	1,963,922	213,153,310	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140164

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

Worksheet Non-CMS W  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	DATA PROCESSING	00550	DATA PROCESSING	5.01
5.02	PURCHASING RECEIVING AND STORES	00560	PURCHASING RECEIVING AND STORES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	00590		5.04
6.00	MAINTENANCE & REPAIRS	00600		6.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	02200		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
35.00	NEONATAL INTENSIVE CARE UNIT	02060	NEONATAL INTENSIVE CARE UNIT	35.00
43.00	NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
50.01	SAME DAY SURGERY	05001		50.01
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
54.01	ONCOLOGY	03480	ONCOLOGY	54.01
54.02	MAMMOGRAPHY	03440	MAMMOGRAPHY	54.02
56.00	RADIOLOGY	05600		56.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	08800		88.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	FAMILY PRACTICE	19201		192.01
192.02	UNUSED SPACE	19202		192.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6

Date/Time Prepared:  
8/29/2016 8:10 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - DIETARY RECLASS</b>					
1.00	CAFETERIA	11.00	1,061,948	944,814	1.00
	TOTALS		1,061,948	944,814	
<b>B - NUTRITIONAL PRODUCT RECLASS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	242,254	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	242,254	
<b>C - MEDICAL SUPPLY RECLASS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	26,596,056	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	26,596,056	
<b>D - SAME DAY SURGERY RECLASS</b>					
1.00	OPERATING ROOM	50.00	1,342,814	660,246	1.00
	TOTALS		1,342,814	660,246	
<b>E - INTEREST RECLASS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	304,720	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	137,253	2.00
	TOTALS		0	441,973	
<b>F - IMPLANTABLE DEVICE RECLASS</b>					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	4,949,727	1.00
	TOTALS		0	4,949,727	
<b>G - CRNA RECLASS</b>					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	3,083,276	1.00
	TOTALS		0	3,083,276	
<b>H - CONTRAST DRUG RECLASS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	502,543	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	502,543	

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Date/Time Prepared:  
8/29/2016 8:10 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
I - ISOTOPE RECLASS					
1.00	RADIOISOTOPE	56.00	0	178,122	1.00
	TOTALS		0	178,122	
J - CANCER CENTER MED DIRECTOR RECLASS					
1.00	ONCOLOGY	54.01	0	29,275	1.00
	TOTALS		0	29,275	
K - EEG MED DIRECTOR RECLASS					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,194	1.00
	TOTALS		0	4,194	
500.00	Grand Total: Increases		2,404,762	37,632,480	500.00

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Date/Time Prepared:  
8/29/2016 8:10 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - DIETARY RECLASS</b>							
1.00	DIETARY	10.00	1,061,948	944,814	0		1.00
	TOTALS		1,061,948	944,814			
<b>B - NUTRITIONAL PRODUCT RECLASS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	659	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	70,591	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	16,193	0		3.00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	271	0		4.00
5.00	NURSERY	43.00	0	18,417	0		5.00
6.00	OPERATING ROOM	50.00	0	20,171	0		6.00
7.00	RECOVERY ROOM	51.00	0	3,431	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	20,480	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	25,394	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,897	0		10.00
11.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	17	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	14,524	0		12.00
13.00	RADIOISOTOPE	56.00	0	314	0		13.00
14.00	LABORATORY	60.00	0	138	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0	8,282	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	1,640	0		16.00
17.00	EMERGENCY	91.00	0	23,702	0		17.00
18.00	MAMMOGRAPHY	54.02	0	736	0		18.00
19.00	DIETARY	10.00	0	15,397	0		19.00
	TOTALS		0	242,254			
<b>C - MEDICAL SUPPLY RECLASS</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	22,397	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	5,276	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	36,287	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	304	0		4.00
5.00	NURSERY	43.00	0	40	0		5.00
6.00	OPERATING ROOM	50.00	0	13,479,334	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	18,018	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	147,123	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	815,760	0		9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	9,321	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	11,845,696	0		11.00
12.00	LABORATORY	60.00	0	46,827	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	111,314	0		13.00
14.00	EMERGENCY	91.00	0	4,279	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	4,938	0		15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,650	0		16.00
17.00	MAMMOGRAPHY	54.02	0	3,539	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	657	0		18.00
19.00	ONCOLOGY	54.01	0	15,317	0		19.00
20.00	RURAL HEALTH CLINIC	88.00	0	15,170	0		20.00
21.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,078	0		21.00
22.00	INTRAVENOUS THERAPY	64.00	0	5,195	0		22.00
23.00	RADIOISOTOPE	56.00	0	536	0		23.00
	TOTALS		0	26,596,056			
<b>D - SAME DAY SURGERY RECLASS</b>							
1.00	SAME DAY SURGERY	50.01	1,342,814	660,246	0		1.00
	TOTALS		1,342,814	660,246			
<b>E - INTEREST RECLASS</b>							
1.00	INTEREST EXPENSE	113.00	0	441,973	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	441,973			
<b>F - IMPLANTABLE DEVICE RECLASS</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,949,727	0		1.00
	TOTALS		0	4,949,727			
<b>G - CRNA RECLASS</b>							
1.00	ANESTHESIOLOGY	53.00	0	3,083,276	0		1.00
	TOTALS		0	3,083,276			
<b>H - CONTRAST DRUG RECLASS</b>							
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	50,820	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	290,394	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	54,194	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	104,899	0		4.00
5.00	OPERATING ROOM	50.00	0	2,236	0		5.00
	TOTALS		0	502,543			

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Date/Time Prepared:  
8/29/2016 8:10 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
I - ISOTOPE RECLASS							
1.00	ELECTROCARDIOLOGY	69.00	0	178,122	0		1.00
	TOTALS		0	178,122			
J - CANCER CENTER MED DIRECTOR RECLASS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	29,275	0		1.00
	TOTALS		0	29,275			
K - EEG MED DIRECTOR RECLASS							
1.00	EMERGENCY	91.00	0	4,194	0		1.00
	TOTALS		0	4,194			
500.00	Grand Total: Decreases		2,404,762	37,632,480			500.00

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 8/29/2016 8:10 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
<b>A - DIETARY RECLASS</b>									
1.00	CAFETERIA	11.00	1,061,948	944,814	DIETARY	10.00	1,061,948	944,814	1.00
	TOTALS		1,061,948	944,814	TOTALS		1,061,948	944,814	
<b>B - NUTRITIONAL PRODUCT RECLASS</b>									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	242,254	CENTRAL SERVICES & SUPPLY	14.00	0	659	1.00
2.00		0.00	0		ADULTS & PEDIATRICS	30.00	0	70,591	2.00
3.00		0.00	0		INTENSIVE CARE UNIT	31.00	0	16,193	3.00
4.00		0.00	0		NEONATAL INTENSIVE CARE UNIT	35.00	0	271	4.00
5.00		0.00	0		NURSERY	43.00	0	18,417	5.00
6.00		0.00	0		OPERATING ROOM	50.00	0	20,171	6.00
7.00		0.00	0		RECOVERY ROOM	51.00	0	3,431	7.00
8.00		0.00	0		DELIVERY ROOM & LABOR ROOM	52.00	0	20,480	8.00
9.00		0.00	0		ANESTHESIOLOGY	53.00	0	25,394	9.00
10.00		0.00	0		RADIOLOGY-DIAGNOSTIC	54.00	0	1,897	10.00
11.00		0.00	0		OTHER ADMINISTRATIVE AND GENERAL	5.04	0	17	11.00
12.00		0.00	0		CARDIAC CATHETERIZATION	59.00	0	14,524	12.00
13.00		0.00	0		RADIOISOTOPE	56.00	0	314	13.00
14.00		0.00	0		LABORATORY	60.00	0	138	14.00
15.00		0.00	0		INTRAVENOUS THERAPY	64.00	0	8,282	15.00
16.00		0.00	0		ELECTROCARDIOLOGY	69.00	0	1,640	16.00
17.00		0.00	0		EMERGENCY	91.00	0	23,702	17.00
18.00		0.00	0		MAMMOGRAPHY	54.02	0	736	18.00
19.00		0.00	0		DIETARY	10.00	0	15,397	19.00
	TOTALS		0	242,254	TOTALS		0	242,254	
<b>C - MEDICAL SUPPLY RECLASS</b>									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	26,596,056	CENTRAL SERVICES & SUPPLY	14.00	0	22,397	1.00
2.00		0.00	0		ADULTS & PEDIATRICS	30.00	0	5,276	2.00
3.00		0.00	0		INTENSIVE CARE UNIT	31.00	0	36,287	3.00
4.00		0.00	0		NURSING ADMINISTRATION	13.00	0	304	4.00
5.00		0.00	0		NURSERY	43.00	0	40	5.00
6.00		0.00	0		OPERATING ROOM	50.00	0	13,479,334	6.00
7.00		0.00	0		DELIVERY ROOM & LABOR ROOM	52.00	0	18,018	7.00
8.00		0.00	0		ANESTHESIOLOGY	53.00	0	147,123	8.00
9.00		0.00	0		RADIOLOGY-DIAGNOSTIC	54.00	0	815,760	9.00
10.00		0.00	0		MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	9,321	10.00
11.00		0.00	0		CARDIAC CATHETERIZATION	59.00	0	11,845,696	11.00
12.00		0.00	0		LABORATORY	60.00	0	46,827	12.00
13.00		0.00	0		RESPIRATORY THERAPY	65.00	0	111,314	13.00
14.00		0.00	0		EMERGENCY	91.00	0	4,279	14.00
15.00		0.00	0		ELECTROCARDIOLOGY	69.00	0	4,938	15.00
16.00		0.00	0		ELECTROENCEPHALOGRAPHY	70.00	0	7,650	16.00
17.00		0.00	0		MAMMOGRAPHY	54.02	0	3,539	17.00
18.00		0.00	0		PHYSICAL THERAPY	66.00	0	657	18.00
19.00		0.00	0		ONCOLOGY	54.01	0	15,317	19.00
20.00		0.00	0		RURAL HEALTH CLINIC	88.00	0	15,170	20.00
21.00		0.00	0		OTHER ADMINISTRATIVE AND GENERAL	5.04	0	1,078	21.00
22.00		0.00	0		INTRAVENOUS THERAPY	64.00	0	5,195	22.00
23.00		0.00	0		RADIOISOTOPE	56.00	0	536	23.00
	TOTALS		0	26,596,056	TOTALS		0	26,596,056	
<b>D - SAME DAY SURGERY RECLASS</b>									
1.00	OPERATING ROOM	50.00	1,342,814	660,246	SAME DAY SURGERY	50.01	1,342,814	660,246	1.00
	TOTALS		1,342,814	660,246	TOTALS		1,342,814	660,246	
<b>E - INTEREST RECLASS</b>									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	304,720	INTEREST EXPENSE	113.00	0	441,973	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	137,253		0.00	0	0	2.00
	TOTALS		0	441,973	TOTALS		0	441,973	
<b>F - IMPLANTABLE DEVICE RECLASS</b>									
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	4,949,727	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	4,949,727	1.00
	TOTALS		0	4,949,727	TOTALS		0	4,949,727	

RECLASSIFICATIONS

Provider CCN: 140164

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
8/29/2016 8:10 pm

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
<b>G - CRNA RECLASS</b>									
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	3,083,276	ANESTHESIOLOGY	53.00	0	3,083,276	1.00
	TOTALS		0	3,083,276	TOTALS		0	3,083,276	
<b>H - CONTRAST DRUG RECLASS</b>									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	502,543	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	50,820	1.00
2.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	290,394	2.00
3.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	54,194	3.00
4.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	104,899	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	2,236	5.00
	TOTALS		0	502,543	TOTALS		0	502,543	
<b>I - ISOTOPE RECLASS</b>									
1.00	RADIOISOTOPE	56.00	0	178,122	ELECTROCARDIOLOGY	69.00	0	178,122	1.00
	TOTALS		0	178,122	TOTALS		0	178,122	
<b>J - CANCER CENTER MED DIRECTOR RECLASS</b>									
1.00	ONCOLOGY	54.01	0	29,275	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	29,275	1.00
	TOTALS		0	29,275	TOTALS		0	29,275	
<b>K - EEG MED DIRECTOR RECLASS</b>									
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,194	EMERGENCY	91.00	0	4,194	1.00
	TOTALS		0	4,194	TOTALS		0	4,194	
500.00	Grand Total: Increases		2,404,762	37,632,480	Grand Total: Decreases		2,404,762	37,632,480	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140164

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	5,957,499	923,499	0	923,499	0	1.00
2.00	Land Improvements	5,202,500	584,464	0	584,464	67,339	2.00
3.00	Buildings and Fixtures	130,360,106	21,517,184	0	21,517,184	2,172,609	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	63,616,498	13,362,343	0	13,362,343	6,972,267	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	205,136,603	36,387,490	0	36,387,490	9,212,215	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	205,136,603	36,387,490	0	36,387,490	9,212,215	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	6,880,998	0				1.00
2.00	Land Improvements	5,719,625	0				2.00
3.00	Buildings and Fixtures	149,704,681	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	70,006,574	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	232,311,878	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	232,311,878	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140164

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
8/29/2016 8:10 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	5,491,209	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,811,469	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	11,302,678	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	5,491,209				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,811,469				2.00
3.00	Total (sum of lines 1-2)	0	11,302,678				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet A-7 Part III Date/Time Prepared: 8/29/2016 8:10 pm
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	162,305,304	0	162,305,304	0.698653	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	70,006,574	0	70,006,574	0.301347	0	2.00
3.00	Total (sum of lines 1-2)	232,311,878	0	232,311,878	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	5,469,634	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,614,894	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,084,528	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	5,469,634	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	11,614,894	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	17,084,528	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140164

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

Worksheet A-8

Date/Time Prepared:  
8/29/2016 8:10 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 #			
			3.00	4.00			
1.00	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-9,182,067				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	38,664,592				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,165,381	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	-88,114	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-14,896	CAFETERIA		11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-3,083,276	NONPHYSICIAN ANESTHETISTS		19.00	0	28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 EMPLOYEE OUTPATIENT PAYMENTS	B	-4,469,281	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.00

33.01	DEBT FORGIVENESS	A	-7,438,657	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		5.04	0	33.01			
				Basis/Code (2)	Amount				Cost Center	Line #	Wkst. A-7 Ref.
33.02	TELEVISION AND RADIO SERVICES	A	-3,317	OTHER ADMINISTRATIVE AND GENERAL		2.00	9	33.02			
33.03	INTEREST INCOME UNRESTRICTED	B	-813,661	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.03			
33.04	LOSS ON 1994 BONDS	A	130,184	CAP REL COSTS-BLDG & FIXT		1.00	9	33.04			
33.05	LOSS ON 1994 BONDS	A	111,659	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.05			
33.06	FUNDED DEPRECIATION	A	-5,029	CAP REL COSTS-BLDG & FIXT		1.00	9	33.06			
33.07	NONALLOWABLE BOND EXPENSE	A	-3,676,814	INTEREST EXPENSE		113.00	0	33.07			
33.08	MISCELLANEOUS INCOME	B	-1,605	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.08			
33.09	SALE OF XRAY SILVER/FILM	B	-4,798	RADIOLOGY-DIAGNOSTIC		54.00	0	33.09			
33.10	OFFSET LOBBYING EXPENSES	A	-28,290	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.10			
33.11	PURCHASE DISCOUNT	B	-12,711	PURCHASING RECEIVING AND STORES		5.02	0	33.11			
33.12	LOSS ON 1991 BONDS	A	165,215	CAP REL COSTS-BLDG & FIXT		1.00	9	33.12			
33.13	LOSS ON 1991 BONDS	A	113,065	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.13			
33.14	LEASEHOLD REVENUE	B	-39,108	MAMMOGRAPHY		54.02	0	33.14			
33.15	VENDING MACHINE INCOME	B	-131	HOUSEKEEPING		9.00	0	33.15			
33.16	PATIENT'S GUEST LODGING EXPENSE	A	-51,517	CARDIAC CATHETERIZATION		59.00	0	33.16			
33.17	LEASEHOLD REVENUE	B	-804,116	CAP REL COSTS-BLDG & FIXT		1.00	9	33.17			
33.18	MEDICAID PROVIDER TAX	A	-6,255,975	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.18			
33.19	CABLE TV	A	-911	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00	0	33.19			
33.20	PERSONAL PORTION OF PROVIDER VEHICLE	A	-6,641	OTHER ADMINISTRATIVE AND GENERAL		5.04	0	33.20			
33.21	SALE OF MEDICAL RECORDS AND ABSTRACT	B	-560	RURAL HEALTH CLINIC		88.00	0	33.21			
33.22	MISCELLANEOUS INCOME	B	-36,731	RURAL HEALTH CLINIC		88.00	0	33.22			
33.23	INTEREST INCOME UNRESTRICTED	B	-22,036	RURAL HEALTH CLINIC		88.00	0	33.23			
33.24	VENDING MACHINE INCOME	B	-858	ELECTROCARDIOLOGY		69.00	0	33.24			
33.25	DEPARTMENTAL PROG REV-RESP	B	-2,097	RESPIRATORY THERAPY		65.00	0	33.25			
33.26	DEPARTMENTAL PROG REV - OP CARDIO	B	-11,500	ELECTROCARDIOLOGY		69.00	0	33.26			
33.27	MISCELLANEOUS INCOME	B	-715	PHYSICAL THERAPY		66.00	0	33.27			
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,963,922					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: 140164

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

Worksheet A-8-1

Date/Time Prepared: 8/29/2016 8:10 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	187,451	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	5,444,765	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	4,990,208	0
4.00	5.01	DATA PROCESSING	HOME OFFICE	7,203,010	0
4.01	5.03	CASHIERING/ACCOUNTS RECEIVAB	HOME OFFICE	3,580,002	0
4.02	5.04	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	17,381,716	0
4.03	66.00	PHYSICAL THERAPY	RENT	77,464	145,224
4.04	5.04	OTHER ADMINISTRATIVE AND GEN	RENT	14,387	27,224
4.05	16.00	MEDICAL RECORDS & LIBRARY	RENT	22,950	51,228
4.06	54.00	RADIOLOGY-DIAGNOSTIC	RENT	5,268	11,472
4.07	60.00	LABORATORY	RENT	7,171	14,652
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			38,914,392	249,800

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

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

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

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

Provider CCN: 140164

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

Worksheet A-8-1

Date/Time Prepared:  
8/29/2016 8:10 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	187,451	9		1.00
2.00	5,444,765	9		2.00
3.00	4,990,208	0		3.00
4.00	7,203,010	0		4.00
4.01	3,580,002	0		4.01
4.02	17,381,716	0		4.02
4.03	-67,760	0		4.03
4.04	-12,837	0		4.04
4.05	-28,278	0		4.05
4.06	-6,204	0		4.06
4.07	-7,481	0		4.07
5.00	38,664,592			5.00

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

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

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

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

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
10.00	CAPTIVE		10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140164

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

Worksheet A-8-2

Date/Time Prepared:  
8/29/2016 8:10 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	DR. A	3,371,504	3,371,504	0	0	0	1.00
2.00	31.00	DR. B	48,880	0	48,880	211,500	376	2.00
3.00	35.00	DR. C	587,182	546,382	40,800	237,100	204	3.00
4.00	50.00	DR. D	364,246	364,246	0	0	0	4.00
5.00	54.02	DR. E	38,880	0	38,880	271,900	240	5.00
6.00	59.00	DR. F	20,000	0	20,000	211,500	100	6.00
7.00	60.00	DR. G	126,760	126,760	0	0	0	7.00
8.00	54.01	DR. H	1,175,371	1,023,877	151,494	211,500	875	8.00
9.00	69.00	DR. I	211,592	211,592	0	0	0	9.00
10.00	70.00	DR. J	11,094	6,900	4,194	211,500	25	10.00
11.00	91.00	DR. K	3,303,060	3,281,290	21,770	211,500	158	11.00
12.00	5.04	DR. L	134,183	114,308	19,875	179,000	132	12.00
13.00	52.00	DR. M	3,760	0	3,760	237,100	24	13.00
14.00	64.00	DR. N	21,241	300	20,941	211,500	108	14.00
200.00			9,417,753	9,047,159	370,594		2,242	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	DR. A	0	0	0	0	0	1.00
2.00	31.00	DR. B	38,233	1,912	0	0	0	2.00
3.00	35.00	DR. C	23,254	1,163	0	0	0	3.00
4.00	50.00	DR. D	0	0	0	0	0	4.00
5.00	54.02	DR. E	31,373	1,569	0	0	0	5.00
6.00	59.00	DR. F	10,168	508	0	0	0	6.00
7.00	60.00	DR. G	0	0	0	0	0	7.00
8.00	54.01	DR. H	88,972	4,449	0	0	0	8.00
9.00	69.00	DR. I	0	0	0	0	0	9.00
10.00	70.00	DR. J	2,542	127	0	0	0	10.00
11.00	91.00	DR. K	16,066	803	0	0	0	11.00
12.00	5.04	DR. L	11,360	568	0	0	0	12.00
13.00	52.00	DR. M	2,736	137	0	0	0	13.00
14.00	64.00	DR. N	10,982	549	0	0	0	14.00
200.00			235,686	11,785	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	DR. A	0	0	0	3,371,504	1.00	
2.00	31.00	DR. B	0	38,233	10,647	10,647	2.00	
3.00	35.00	DR. C	0	23,254	17,546	563,928	3.00	
4.00	50.00	DR. D	0	0	0	364,246	4.00	
5.00	54.02	DR. E	0	31,373	7,507	7,507	5.00	
6.00	59.00	DR. F	0	10,168	9,832	9,832	6.00	
7.00	60.00	DR. G	0	0	0	126,760	7.00	
8.00	54.01	DR. H	0	88,972	62,522	1,086,399	8.00	
9.00	69.00	DR. I	0	0	0	211,592	9.00	
10.00	70.00	DR. J	0	2,542	1,652	8,552	10.00	
11.00	91.00	DR. K	0	16,066	5,704	3,286,994	11.00	
12.00	5.04	DR. L	0	11,360	8,515	122,823	12.00	
13.00	52.00	DR. M	0	2,736	1,024	1,024	13.00	
14.00	64.00	DR. N	0	10,982	9,959	10,259	14.00	
200.00			0	235,686	134,908	9,182,067	200.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

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

Worksheet B  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,469,634	5,469,634			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	11,614,894		11,614,894		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	22,688,936	16,235	5,640	22,710,811	4.00
5.01 00550	DATA PROCESSING	7,203,010	25,778	0	0	7,228,788 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	337,893	60,191	22,914	79,396	7,361 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,291,704	70,085	552	233,567	154,587 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	27,696,159	1,189,173	325,888	1,875,017	566,819 5.04
6.00 00600	MAINTENANCE & REPAIRS	1,744,897	628,219	3,066	236,134	154,587 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,380,539	15,582	0	13,440	0 8.00
9.00 00900	HOUSEKEEPING	1,564,752	46,617	4,283	426,099	29,445 9.00
10.00 01000	DIETARY	682,071	68,253	37,122	132,744	88,335 10.00
11.00 01100	CAFETERIA	826,485	78,609	1,927	381,933	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,130,665	58,327	461,254	392,304	73,613 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	389,117	47,780	4,225	101,322	29,445 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	486,948	0	7,231	187,530	169,310 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,083,107	0	0	389,543	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,185,759	0	0	0	0 22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	17,311,956	938,656	496,334	5,096,316	1,656,292 30.00
31.00 03100	INTENSIVE CARE UNIT	3,482,327	127,393	193,700	1,032,241	257,645 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,009,990	29,602	111,175	341,051	51,529 35.00
43.00 04300	NURSERY	177,934	14,562	6,991	1,235	14,723 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	9,877,157	522,844	2,330,893	1,779,823	647,794 50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00 05100	RECOVERY ROOM	746,932	61,131	67,203	256,388	88,335 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,203,181	147,101	144,074	1,361,847	176,671 52.00
53.00 05300	ANESTHESIOLOGY	964,521	6,676	120,516	148,940	7,361 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,008,297	156,883	1,497,316	1,003,072	279,729 54.00
54.01 03480	ONCOLOGY	1,865,908	160,755	2,024,155	330,257	228,200 54.01
54.02 03440	MAMMOGRAPHY	1,261,284	0	385,833	229,425	257,645 54.02
56.00 05600	RADIOISOTOPE	1,580,485	28,630	80,482	93,170	36,806 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	404,054	20,090	884,497	88,028	7,361 58.00
59.00 05900	CARDIAC CATHETERIZATION	8,133,247	212,359	1,059,770	1,406,222	449,039 59.00
60.00 06000	LABORATORY	6,735,772	121,737	403,462	818,192	294,452 60.00
64.00 06400	INTRAVENOUS THERAPY	486,453	72,172	12,206	114,777	14,723 64.00
65.00 06500	RESPIRATORY THERAPY	1,440,630	24,026	74,946	443,233	58,890 65.00
66.00 06600	PHYSICAL THERAPY	2,856,554	27,563	35,987	792,817	419,594 66.00
69.00 06900	ELECTROCARDIOLOGY	7,792,671	35,720	321,271	451,808	169,310 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	125,387	8,747	71,069	29,973	14,723 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,646,329	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,949,727	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	16,562,534	38,827	56,795	1,031,514	154,587 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	1,372,343	0	11,224	137,729	309,174 88.00
91.00 09100	EMERGENCY	4,272,419	151,960	349,194	1,273,724	360,703 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	213,044,662	5,212,283	11,613,195	22,710,811	7,228,788 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,190	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	108,648	117,324	1,699	0	0 192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	0 192.01
192.02 19202	UNUSED SPACE	0	105,837	0	0	0 192.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	213,153,310	5,469,634	11,614,894	22,710,811	7,228,788 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

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

Worksheet B  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	507,755					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,042	4,751,537				5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	90	0	31,653,146	31,653,146		5.04
6.00	00600	MAINTENANCE & REPAIRS	1	0	2,766,904	482,540	3,249,444	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	39	0	1,409,600	245,830	14,549	8.00
9.00	00900	HOUSEKEEPING	233	0	2,071,429	361,251	43,529	9.00
10.00	01000	DIETARY	87	0	1,008,612	175,899	63,732	10.00
11.00	01100	CAFETERIA	249	0	1,289,203	224,833	73,402	11.00
13.00	01300	NURSING ADMINISTRATION	28	0	2,116,191	369,057	54,464	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,613	0	573,502	100,017	44,615	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	851,019	148,415	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,472,650	256,826	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,185,759	206,793	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	78,657	229,643	25,807,854	4,500,873	876,480	30.00
31.00	03100	INTENSIVE CARE UNIT	24,739	31,622	5,149,667	898,086	118,955	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	111	41,941	1,585,399	276,489	27,641	35.00
43.00	04300	NURSERY	8,056	10,506	234,007	40,810	13,597	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	208,481	702,915	16,069,907	2,802,544	488,211	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	1,062	64,482	1,285,533	224,193	57,082	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,683	89,257	6,137,814	1,070,416	137,357	52.00
53.00	05300	ANESTHESIOLOGY	24,530	100,523	1,373,067	239,459	6,233	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,282	569,454	7,539,033	1,314,785	146,492	54.00
54.01	03480	ONCOLOGY	42	237,091	4,846,408	845,199	150,107	54.01
54.02	03440	MAMMOGRAPHY	833	49,883	2,184,903	381,041	0	54.02
56.00	05600	RADIOISOTOPE	732	94,299	1,914,604	333,901	26,734	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	593	113,752	1,518,375	264,800	18,760	58.00
59.00	05900	CARDIAC CATHETERIZATION	61,997	272,919	11,595,553	2,022,230	198,292	59.00
60.00	06000	LABORATORY	9,942	437,877	8,821,434	1,538,432	113,673	60.00
64.00	06400	INTRAVENOUS THERAPY	4,471	14,648	719,450	125,470	67,392	64.00
65.00	06500	RESPIRATORY THERAPY	5,077	58,952	2,105,754	367,237	22,434	65.00
66.00	06600	PHYSICAL THERAPY	1,442	94,218	4,228,175	737,381	25,737	66.00
69.00	06900	ELECTROCARDIOLOGY	2,716	297,395	9,070,891	1,581,936	33,354	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	276	3,616	253,791	44,260	8,167	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	227,725	21,874,054	3,814,769	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	383,290	5,333,017	930,062	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,576	397,050	18,246,883	3,182,202	36,255	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	475	8,150	1,839,095	320,733	0	88.00
91.00	09100	EMERGENCY	24,600	220,329	6,652,929	1,160,251	141,895	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	507,755	4,751,537	212,785,612	31,589,020	3,009,139	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	34,190	5,963	31,926	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	227,671	39,705	109,553	192.00
192.01	19201	FAMILY PRACTICE	0	0	0	0	0	192.01
192.02	19202	UNUSED SPACE	0	0	105,837	18,458	98,826	192.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	507,755	4,751,537	213,153,310	31,653,146	3,249,444	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet B Part I Date/Time Prepared: 8/29/2016 8:10 pm
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,669,979				8.00
9.00	00900	HOUSEKEEPING	0	2,476,209			9.00
10.00	01000	DIETARY	0	49,450	1,297,693		10.00
11.00	01100	CAFETERIA	0	56,953	0	1,644,391	11.00
13.00	01300	NURSING ADMINISTRATION	0	42,259	0	24,942	2,606,913
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,618	0	19,597	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	28,505	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	33,850	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,405,278	680,070	1,092,002	448,955	1,100,498
31.00	03100	INTENSIVE CARE UNIT	181,935	92,298	141,376	78,389	190,310
35.00	02060	NEONATAL INTENSIVE CARE UNIT	82,766	21,447	64,315	24,942	60,476
43.00	04300	NURSERY	0	10,550	0	1,782	276
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	378,807	0	158,560	391,092
50.01	05001	SAME DAY SURGERY	0	0	0	0	0
51.00	05100	RECOVERY ROOM	0	44,291	0	16,034	39,398
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	106,577	0	112,239	277,780
53.00	05300	ANESTHESIOLOGY	0	4,837	0	8,908	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	113,664	0	80,171	0
54.01	03480	ONCOLOGY	0	116,469	0	26,724	0
54.02	03440	MAMMOGRAPHY	0	0	0	26,724	0
56.00	05600	RADIOISOTOPE	0	20,743	0	5,345	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,556	0	7,126	0
59.00	05900	CARDIAC CATHETERIZATION	0	153,857	0	105,113	260,070
60.00	06000	LABORATORY	0	88,200	0	94,423	0
64.00	06400	INTRAVENOUS THERAPY	0	52,290	0	12,471	0
65.00	06500	RESPIRATORY THERAPY	0	17,407	0	39,195	12,441
66.00	06600	PHYSICAL THERAPY	0	19,969	0	58,792	0
69.00	06900	ELECTROCARDIOLOGY	0	25,879	0	40,976	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,337	0	3,563	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,130	0	53,447	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	21,379	0
91.00	09100	EMERGENCY	0	110,097	0	112,239	274,572
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,669,979	2,289,755	1,297,693	1,644,391	2,606,913
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,771	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	85,003	0	0	0
192.01	19201	FAMILY PRACTICE	0	0	0	0	0
192.02	19202	UNUSED SPACE	0	76,680	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)	1,669,979	2,476,209	1,297,693	1,644,391	2,606,913

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

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

Worksheet B  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description	INTERNS & RESIDENTS					
	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	14.00	16.00	19.00	21.00	22.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00550 DATA PROCESSING						5.01
5.02 00560 PURCHASING RECEIVING AND STORES						5.02
5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04 00590 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00 00600 MAINTENANCE & REPAIRS						6.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	772,349					14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1,027,939				16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		1,729,476		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			1,426,402	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	188	49,666	0	336,385	277,437	30.00
31.00 03100 INTENSIVE CARE UNIT	973	6,839	0	16,755	13,819	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	9,071	0	1,211	999	35.00
43.00 04300 NURSERY	1	2,272	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	311,665	152,333	0	68,854	56,788	50.00
50.01 05001 SAME DAY SURGERY	0	0	0	0	0	50.01
51.00 05100 RECOVERY ROOM	0	13,946	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	563	19,304	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	5,250	21,740	0	6,349	5,236	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	28,532	123,157	0	9,458	7,800	54.00
54.01 03480 ONCOLOGY	547	51,276	0	0	0	54.01
54.02 03440 MAMMOGRAPHY	126	10,788	0	0	0	54.02
56.00 05600 RADIOISOTOPE	19	20,394	0	0	0	56.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	333	24,601	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	416,538	59,025	0	0	0	59.00
60.00 06000 LABORATORY	1,671	94,701	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	185	3,168	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	3,972	12,750	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	23	20,377	0	31,024	25,587	66.00
69.00 06900 ELECTROCARDIOLOGY	176	64,318	0	6,872	5,668	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	273	782	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	652	49,251	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	82,895	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	85,871	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	541	1,763	0	292,533	241,269	88.00
91.00 09100 EMERGENCY	121	47,651	0	78,116	64,427	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	772,349	1,027,939	0	847,557	699,030	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 FAMILY PRACTICE	0	0	0	881,919	727,372	192.01
192.02 19202 UNUSED SPACE	0	0	0	0	0	192.02
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	772,349	1,027,939	0	1,729,476	1,426,402	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140164

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

Worksheet B  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00580				5.03
5.04	00590				5.04
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
21.00	02100				21.00
22.00	02200				22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	36,575,686	-613,822	35,961,864	30.00
31.00	03100	6,889,402	-30,574	6,858,828	31.00
35.00	02060	2,154,756	-2,210	2,152,546	35.00
43.00	04300	303,295	0	303,295	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	20,878,761	-125,642	20,753,119	50.00
50.01	05001	0	0	0	50.01
51.00	05100	1,680,477	0	1,680,477	51.00
52.00	05200	7,862,050	0	7,862,050	52.00
53.00	05300	1,671,079	-11,585	1,659,494	53.00
54.00	05400	9,363,092	-17,258	9,345,834	54.00
54.01	03480	6,036,730	0	6,036,730	54.01
54.02	03440	2,603,582	0	2,603,582	54.02
56.00	05600	2,321,740	0	2,321,740	56.00
58.00	05800	1,848,551	0	1,848,551	58.00
59.00	05900	14,810,678	0	14,810,678	59.00
60.00	06000	10,752,534	0	10,752,534	60.00
64.00	06400	980,426	0	980,426	64.00
65.00	06500	2,581,190	0	2,581,190	65.00
66.00	06600	5,147,065	-56,611	5,090,454	66.00
69.00	06900	10,830,070	-12,540	10,817,530	69.00
70.00	07000	317,173	0	317,173	70.00
71.00	07100	25,738,726	0	25,738,726	71.00
72.00	07200	6,345,974	0	6,345,974	72.00
73.00	07300	21,632,788	0	21,632,788	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	2,717,313	-533,802	2,183,511	88.00
91.00	09100	8,642,298	-142,543	8,499,755	91.00
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		210,685,436	-1,546,587	209,138,849	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	96,850	0	96,850	190.00
192.00	19200	461,932	0	461,932	192.00
192.01	19201	1,609,291	-1,609,291	0	192.01
192.02	19202	299,801	0	299,801	192.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		213,153,310	-3,155,878	209,997,432	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140164

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

Worksheet Non-CMS W  
Date/Time Prepared:  
8/29/2016 8:10 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	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	3	GROSS SALARIES	4.00
5.01	DATA PROCESSING	4	NUMBER OF PCS	5.01
5.02	PURCHASING RECEIVING AND STORES	5	PURCHASING SUPPLIES	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	6	GROSS REVENUE	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-5	ACCUM. COST	5.04
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
8.00	LAUNDRY & LINEN SERVICE	7	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	NUMBER OF FTES	11.00
13.00	NURSING ADMINISTRATION	10	DIRECT NURSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
16.00	MEDICAL RECORDS & LIBRARY	6	GROSS REVENUE	16.00
19.00	NONPHYSICIAN ANESTHETISTS	12	ASSIGNED TIME	19.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	13	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	13	ASSIGNED TIME	22.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

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

Worksheet B  
Part II  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	16,235	5,640	21,875	4.00
5.01 00550	DATA PROCESSING	0	25,778	0	25,778	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	0	60,191	22,914	83,105	5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	70,085	552	70,637	5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	0	1,189,173	325,888	1,515,061	5.04
6.00 00600	MAINTENANCE & REPAIRS	0	628,219	3,066	631,285	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,582	0	15,582	8.00
9.00 00900	HOUSEKEEPING	0	46,617	4,283	50,900	9.00
10.00 01000	DIETARY	0	68,253	37,122	105,375	10.00
11.00 01100	CAFETERIA	0	78,609	1,927	80,536	11.00
13.00 01300	NURSING ADMINISTRATION	0	58,327	461,254	519,581	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	47,780	4,225	52,005	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	7,231	7,231	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	938,656	496,334	1,434,990	30.00
31.00 03100	INTENSIVE CARE UNIT	0	127,393	193,700	321,093	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	29,602	111,175	140,777	35.00
43.00 04300	NURSERY	0	14,562	6,991	21,553	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	522,844	2,330,893	2,853,737	50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	0	61,131	67,203	128,334	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	147,101	144,074	291,175	52.00
53.00 05300	ANESTHESIOLOGY	0	6,676	120,516	127,192	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	156,883	1,497,316	1,654,199	54.00
54.01 03480	ONCOLOGY	0	160,755	2,024,155	2,184,910	54.01
54.02 03440	MAMMOGRAPHY	0	0	385,833	385,833	54.02
56.00 05600	RADIOISOTOPE	0	28,630	80,482	109,112	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	20,090	884,497	904,587	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	212,359	1,059,770	1,272,129	59.00
60.00 06000	LABORATORY	0	121,737	403,462	525,199	60.00
64.00 06400	INTRAVENOUS THERAPY	0	72,172	12,206	84,378	64.00
65.00 06500	RESPIRATORY THERAPY	0	24,026	74,946	98,972	65.00
66.00 06600	PHYSICAL THERAPY	0	27,563	35,987	63,550	66.00
69.00 06900	ELECTROCARDIOLOGY	0	35,720	321,271	356,991	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	8,747	71,069	79,816	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	38,827	56,795	95,622	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	11,224	11,224	88.00
91.00 09100	EMERGENCY	0	151,960	349,194	501,154	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	5,212,283	11,613,195	16,825,478	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,190	0	34,190	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	117,324	1,699	119,023	192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	192.01
192.02 19202	UNUSED SPACE	0	105,837	0	105,837	192.02
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)	0	5,469,634	11,614,894	17,084,528	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

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

Worksheet B Part II Date/Time Prepared: 8/29/2016 8:10 pm

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.01	5.02	5.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550	25,778					5.01
5.02	00560	26	83,207				5.02
5.03	00580	551	171	71,584			5.03
5.04	00590	2,021	15	0	1,518,901		5.04
6.00	00600	551	0	0	23,156	655,219	6.00
8.00	00800	0	6	0	11,797	2,934	8.00
9.00	00900	105	38	0	17,336	8,777	9.00
10.00	01000	315	14	0	8,441	12,851	10.00
11.00	01100	0	41	0	10,789	14,801	11.00
13.00	01300	263	5	0	17,710	10,982	13.00
14.00	01400	105	264	0	4,800	8,996	14.00
16.00	01600	604	0	0	7,122	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	12,325	0	21.00
22.00	02200	0	0	0	9,924	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,905	12,890	3,473	215,914	176,732	30.00
31.00	03100	919	4,054	478	43,098	23,986	31.00
35.00	02060	184	18	634	13,268	5,574	35.00
43.00	04300	53	1,320	159	1,958	2,742	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,310	34,165	10,350	134,489	98,443	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	315	174	975	10,759	11,510	51.00
52.00	05200	630	2,570	1,350	51,367	27,697	52.00
53.00	05300	26	4,020	1,520	11,491	1,257	53.00
54.00	05400	998	3,979	8,613	63,094	29,539	54.00
54.01	03480	814	7	3,586	40,560	30,268	54.01
54.02	03440	919	136	754	18,285	0	54.02
56.00	05600	131	120	1,426	16,023	5,391	56.00
58.00	05800	26	97	1,721	12,707	3,783	58.00
59.00	05900	1,601	10,160	4,128	97,043	39,984	59.00
60.00	06000	1,050	1,629	6,623	73,827	22,921	60.00
64.00	06400	53	733	222	6,021	13,589	64.00
65.00	06500	210	832	892	17,623	4,524	65.00
66.00	06600	1,496	236	1,425	35,386	5,190	66.00
69.00	06900	604	445	4,498	75,914	6,725	69.00
70.00	07000	53	45	55	2,124	1,647	70.00
71.00	07100	0	0	3,444	183,064	0	71.00
72.00	07200	0	0	5,797	44,632	0	72.00
73.00	07300	551	914	6,005	152,708	7,310	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	1,103	78	123	15,391	0	88.00
91.00	09100	1,286	4,031	3,333	55,678	28,612	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		25,778	83,207	71,584	1,515,824	606,765	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	286	6,437	190.00
192.00	19200	0	0	0	1,905	22,090	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	886	19,927	192.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		25,778	83,207	71,584	1,518,901	655,219	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140164

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

Worksheet B  
Part II  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	30,332					9.00
10.00	01000	0	77,566				10.00
11.00	01100	0	1,549	128,673			11.00
13.00	01300	0	1,784	0	108,318		13.00
14.00	01400	0	1,324	0	1,643	551,885	14.00
16.00	01600	0	1,084	0	1,291	0	16.00
19.00	01900	0	0	0	1,878	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	2,230	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	25,525	21,303	108,278	29,573	232,976	30.00
31.00	03100	3,304	2,891	14,018	5,164	40,289	31.00
35.00	02060	1,503	672	6,377	1,643	12,803	35.00
43.00	04300	0	330	0	117	58	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	11,866	0	10,445	82,794	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	0	1,387	0	1,056	8,341	51.00
52.00	05200	0	3,338	0	7,393	58,806	52.00
53.00	05300	0	152	0	587	0	53.00
54.00	05400	0	3,560	0	5,281	0	54.00
54.01	03480	0	3,648	0	1,760	0	54.01
54.02	03440	0	0	0	1,760	0	54.02
56.00	05600	0	650	0	352	0	56.00
58.00	05800	0	456	0	469	0	58.00
59.00	05900	0	4,819	0	6,924	55,057	59.00
60.00	06000	0	2,763	0	6,220	0	60.00
64.00	06400	0	1,638	0	821	0	64.00
65.00	06500	0	545	0	2,582	2,634	65.00
66.00	06600	0	626	0	3,873	0	66.00
69.00	06900	0	811	0	2,699	0	69.00
70.00	07000	0	199	0	235	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	881	0	3,521	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	1,408	0	88.00
91.00	09100	0	3,449	0	7,393	58,127	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		30,332	71,725	128,673	108,318	551,885	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	776	0	0	0	190.00
192.00	19200	0	2,663	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	2,402	0	0	0	192.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		30,332	77,566	128,673	108,318	551,885	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet B Part II Date/Time Prepared: 8/29/2016 8:10 pm
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Cost Center Description	INTERNS & RESIDENTS					
	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	14.00	16.00	19.00	21.00	22.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00 00600	MAINTENANCE & REPAIRS					6.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	68,642				14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,015			16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		12,700	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00
						12,154
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	17	838			30.00
31.00 03100	INTENSIVE CARE UNIT	86	115			31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	0	153			35.00
43.00 04300	NURSERY	0	38			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	27,696	2,237			50.00
50.01 05001	SAME DAY SURGERY	0	0			50.01
51.00 05100	RECOVERY ROOM	0	235			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	50	326			52.00
53.00 05300	ANESTHESIOLOGY	467	367			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,536	2,079			54.00
54.01 03480	ONCOLOGY	49	866			54.01
54.02 03440	MAMMOGRAPHY	11	182			54.02
56.00 05600	RADIOISOTOPE	2	344			56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	30	415			58.00
59.00 05900	CARDIAC CATHETERIZATION	37,022	996			59.00
60.00 06000	LABORATORY	148	1,599			60.00
64.00 06400	INTRAVENOUS THERAPY	16	53			64.00
65.00 06500	RESPIRATORY THERAPY	353	215			65.00
66.00 06600	PHYSICAL THERAPY	2	344			66.00
69.00 06900	ELECTROCARDIOLOGY	16	1,086			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	24	13			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58	831			71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,399			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,450			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	48	30			88.00
91.00 09100	EMERGENCY	11	804			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	68,642	17,015	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0			192.00
192.01 19201	FAMILY PRACTICE	0	0			192.01
192.02 19202	UNUSED SPACE	0	0			192.02
200.00	Cross Foot Adjustments			0	12,700	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	68,642	17,015	0	12,700	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet B Part II Date/Time Prepared: 8/29/2016 8:10 pm
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00550				5.01
5.02	00560				5.02
5.03	00580				5.03
5.04	00590				5.04
6.00	00600				6.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
16.00	01600				16.00
19.00	01900				19.00
21.00	02100				21.00
22.00	02200				22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	2,273,344	0	2,273,344	30.00
31.00	03100	460,488	0	460,488	31.00
35.00	02060	183,934	0	183,934	35.00
43.00	04300	28,329	0	28,329	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	3,270,244	0	3,270,244	50.00
50.01	05001	0	0	0	50.01
51.00	05100	163,333	0	163,333	51.00
52.00	05200	446,012	0	446,012	52.00
53.00	05300	147,222	0	147,222	53.00
54.00	05400	1,774,843	0	1,774,843	54.00
54.01	03480	2,266,786	0	2,266,786	54.01
54.02	03440	408,101	0	408,101	54.02
56.00	05600	133,641	0	133,641	56.00
58.00	05800	924,376	0	924,376	58.00
59.00	05900	1,531,216	0	1,531,216	59.00
60.00	06000	642,766	0	642,766	60.00
64.00	06400	107,634	0	107,634	64.00
65.00	06500	129,808	0	129,808	65.00
66.00	06600	112,891	0	112,891	66.00
69.00	06900	450,224	0	450,224	69.00
70.00	07000	84,240	0	84,240	70.00
71.00	07100	187,397	0	187,397	71.00
72.00	07200	51,828	0	51,828	72.00
73.00	07300	269,954	0	269,954	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	29,538	0	29,538	88.00
91.00	09100	665,103	0	665,103	91.00
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
118.00		16,743,252	0	16,743,252	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	41,689	0	41,689	190.00
192.00	19200	145,681	0	145,681	192.00
192.01	19201	0	0	0	192.01
192.02	19202	129,052	0	129,052	192.02
200.00		24,854	0	24,854	200.00
201.00		0	0	0	201.00
202.00		17,084,528	0	17,084,528	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

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

Worksheet B-1  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (NUMBER OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASING SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	343,309				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		5,811,471			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,019	2,822	63,146,525		4.00
5.01 00550	DATA PROCESSING	1,618	0	0	982	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	3,778	11,465	220,758	1	9,853,328 5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	4,399	276	649,422	21	20,221 5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	74,640	163,057	5,213,407	77	1,756 5.04
6.00 00600	MAINTENANCE & REPAIRS	39,431	1,534	656,560	21	19 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	978	0	37,368	0	756 8.00
9.00 00900	HOUSEKEEPING	2,926	2,143	1,184,750	4	4,530 9.00
10.00 01000	DIETARY	4,284	18,574	369,090	12	1,680 10.00
11.00 01100	CAFETERIA	4,934	964	1,061,948	0	4,832 11.00
13.00 01300	NURSING ADMINISTRATION	3,661	230,787	1,090,785	10	539 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,999	2,114	281,721	4	31,293 14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,618	521,420	23	0 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,083,107	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	58,916	248,339	14,170,162	225	1,526,404 30.00
31.00 03100	INTENSIVE CARE UNIT	7,996	96,917	2,870,103	35	480,087 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,858	55,626	948,279	7	2,158 35.00
43.00 04300	NURSERY	914	3,498	3,433	2	156,340 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	32,817	1,166,253	4,948,722	88	4,045,736 50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	0 50.01
51.00 05100	RECOVERY ROOM	3,837	33,625	712,877	12	20,602 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,233	72,087	3,786,559	24	304,332 52.00
53.00 05300	ANESTHESIOLOGY	419	60,300	414,120	1	476,022 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,847	749,177	2,789,000	38	471,213 54.00
54.01 03480	ONCOLOGY	10,090	1,012,779	918,266	31	810 54.01
54.02 03440	MAMMOGRAPHY	0	193,050	637,907	35	16,163 54.02
56.00 05600	RADIOLOGY-SOFT COPY	1,797	40,269	259,055	5	14,200 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,261	442,555	244,757	1	11,511 58.00
59.00 05900	CARDIAC CATHETERIZATION	13,329	530,252	3,909,942	61	1,203,094 59.00
60.00 06000	LABORATORY	7,641	201,871	2,274,948	40	192,923 60.00
64.00 06400	INTRAVENOUS THERAPY	4,530	6,107	319,132	2	86,759 64.00
65.00 06500	RESPIRATORY THERAPY	1,508	37,499	1,232,392	8	98,514 65.00
66.00 06600	PHYSICAL THERAPY	1,730	18,006	2,204,395	57	27,982 66.00
69.00 06900	ELECTROCARDIOLOGY	2,242	160,747	1,256,232	23	52,710 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	549	35,559	83,339	2	5,347 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,437	28,417	2,868,081	21	108,205 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	5,616	382,951	42	9,211 88.00
91.00 09100	EMERGENCY	9,538	174,718	3,541,537	49	477,379 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	327,156	5,810,621	63,146,525	982	9,853,328 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,146	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	7,364	850	0	0	0 192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	0 192.01
192.02 19202	UNUSED SPACE	6,643	0	0	0	0 192.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	5,469,634	11,614,894	22,710,811	7,228,788	507,755 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15.932102	1.998615	0.359653	7,361.291242	0.051531 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			21,875	25,778	83,207 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000346	26.250509	0.008445 205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet B-1 Date/Time Prepared: 8/29/2016 8:10 pm		
Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation 5A.04	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST) 5.04	MAINTENANCE & REPAIRS (SQUARE FEET) 6.00	LAUNDRY & LINEN SERVICE (PATIENT DAYS) 8.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00550	DATA PROCESSING					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00580	CASHIERING/ACCOUNTS RECEIVABLE	826,005,854				5.03
5.04 00590	OTHER ADMINISTRATIVE AND GENERAL	0	-31,653,146	181,500,164		5.04
6.00 00600	MAINTENANCE & REPAIRS	0	0	2,766,904	218,424	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	1,409,600	978	8.00
9.00 00900	HOUSEKEEPING	0	0	2,071,429	2,926	9.00
10.00 01000	DIETARY	0	0	1,008,612	4,284	10.00
11.00 01100	CAFETERIA	0	0	1,289,203	4,934	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	2,116,191	3,661	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	573,502	2,999	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	851,019	0	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,472,650	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1,185,759	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	39,924,080	0	25,807,854	58,916	30.00
31.00 03100	INTENSIVE CARE UNIT	5,497,549	0	5,149,667	7,996	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	7,291,495	0	1,585,399	1,858	35.00
43.00 04300	NURSERY	1,826,429	0	234,007	914	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	122,142,650	0	16,069,907	32,817	50.00
50.01 05001	SAME DAY SURGERY	0	0	0	0	50.01
51.00 05100	RECOVERY ROOM	11,210,280	0	1,285,533	3,837	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	15,517,528	0	6,137,814	9,233	52.00
53.00 05300	ANESTHESIOLOGY	17,476,101	0	1,373,067	419	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	99,001,039	0	7,539,033	9,847	54.00
54.01 03480	ONCOLOGY	41,218,959	0	4,846,408	10,090	54.01
54.02 03440	MAMMOGRAPHY	8,672,353	0	2,184,903	0	54.02
56.00 05600	RADIOISOTOPE	16,394,113	0	1,914,604	1,797	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	19,776,070	0	1,518,375	1,261	58.00
59.00 05900	CARDIAC CATHETERIZATION	47,447,660	0	11,595,553	13,329	59.00
60.00 06000	LABORATORY	76,126,037	0	8,821,434	7,641	60.00
64.00 06400	INTRAVENOUS THERAPY	2,546,575	0	719,450	4,530	64.00
65.00 06500	RESPIRATORY THERAPY	10,248,871	0	2,105,754	1,508	65.00
66.00 06600	PHYSICAL THERAPY	16,380,014	0	4,228,175	1,730	66.00
69.00 06900	ELECTROCARDIOLOGY	51,702,969	0	9,070,891	2,242	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	628,670	0	253,791	549	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,590,619	0	21,874,054	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	66,635,909	0	5,333,017	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	69,028,133	0	18,246,883	2,437	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	1,416,975	0	1,839,095	0	88.00
91.00 09100	EMERGENCY	38,304,776	0	6,652,929	9,538	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	826,005,854	-31,653,146	181,132,466	202,271	35,330
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	34,190	2,146	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	227,671	7,364	192.00
192.01 19201	FAMILY PRACTICE	0	0	0	0	192.01
192.02 19202	UNUSED SPACE	0	0	105,837	6,643	192.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,751,537		31,653,146	3,249,444	1,669,979
203.00	Unit cost multiplier (Wkst. B, Part I)	0.005752		0.174397	14.876772	47.268016
204.00	Cost to be allocated (per Wkst. B, Part II)	71,584		1,518,901	655,219	30,332
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000087		0.008369	2.999757	0.858534

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

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

Worksheet B-1

Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTES)	NURSING ADMINISTRATION  (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00560						5.02
5.03	00580						5.03
5.04	00590						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	214,520					9.00
10.00	01000	4,284	105,990				10.00
11.00	01100	4,934	0	923			11.00
13.00	01300	3,661	0	14	1,239,406		13.00
14.00	01400	2,999	0	11	0	21,644,949	14.00
16.00	01600	0	0	16	0	0	16.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	19	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	58,916	89,190	252	523,211	5,262	30.00
31.00	03100	7,996	11,547	44	90,479	27,258	31.00
35.00	02060	1,858	5,253	14	28,752	0	35.00
43.00	04300	914	0	1	131	40	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	32,817	0	89	185,937	8,734,267	50.00
50.01	05001	0	0	0	0	0	50.01
51.00	05100	3,837	0	9	18,731	0	51.00
52.00	05200	9,233	0	63	132,065	15,774	52.00
53.00	05300	419	0	5	0	147,123	53.00
54.00	05400	9,847	0	45	0	799,604	54.00
54.01	03480	10,090	0	15	0	15,317	54.01
54.02	03440	0	0	15	0	3,539	54.02
56.00	05600	1,797	0	3	0	536	56.00
58.00	05800	1,261	0	4	0	9,321	58.00
59.00	05900	13,329	0	59	123,645	11,673,493	59.00
60.00	06000	7,641	0	53	0	46,827	60.00
64.00	06400	4,530	0	7	0	5,195	64.00
65.00	06500	1,508	0	22	5,915	111,314	65.00
66.00	06600	1,730	0	33	0	657	66.00
69.00	06900	2,242	0	23	0	4,938	69.00
70.00	07000	549	0	2	0	7,650	70.00
71.00	07100	0	0	0	0	18,275	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,437	0	30	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	12	0	15,170	88.00
91.00	09100	9,538	0	63	130,540	3,389	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		198,367	105,990	923	1,239,406	21,644,949	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	2,146	0	0	0	0	190.00
192.00	19200	7,364	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	6,643	0	0	0	0	192.02
200.00							200.00
201.00							201.00
202.00		2,476,209	1,297,693	1,644,391	2,606,913	772,349	202.00
203.00		11.543022	12.243542	1,781.572048	2.103357	0.035683	203.00
204.00		77,566	128,673	108,318	551,885	68,642	204.00
205.00		0.361579	1.214011	117.354280	0.445282	0.003171	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140164

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

Worksheet B-1

Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
			16.00	19.00		21.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01 00550 DATA PROCESSING					5.01	
5.02 00560 PURCHASING RECEIVING AND STORES					5.02	
5.03 00580 CASHIERING/ACCOUNTS RECEIVABLE					5.03	
5.04 00590 OTHER ADMINISTRATIVE AND GENERAL					5.04	
6.00 00600 MAINTENANCE & REPAIRS					6.00	
8.00 00800 LAUNDRY & LINEN SERVICE					8.00	
9.00 00900 HOUSEKEEPING					9.00	
10.00 01000 DIETARY					10.00	
11.00 01100 CAFETERIA					11.00	
13.00 01300 NURSING ADMINISTRATION					13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	826,005,854				16.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	100			19.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0		52,848		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0			52,848	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	39,924,080	0	10,279	10,279	30.00	
31.00 03100 INTENSIVE CARE UNIT	5,497,549	0	512	512	31.00	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	7,291,495	0	37	37	35.00	
43.00 04300 NURSERY	1,826,429	0	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	122,142,650	0	2,104	2,104	50.00	
50.01 05001 SAME DAY SURGERY	0	0	0	0	50.01	
51.00 05100 RECOVERY ROOM	11,210,280	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	15,517,528	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	17,476,101	100	194	194	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	99,001,039	0	289	289	54.00	
54.01 03480 ONCOLOGY	41,218,959	0	0	0	54.01	
54.02 03440 MAMMOGRAPHY	8,672,353	0	0	0	54.02	
56.00 05600 RADIOISOTOPE	16,394,113	0	0	0	56.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	19,776,070	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	47,447,660	0	0	0	59.00	
60.00 06000 LABORATORY	76,126,037	0	0	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	2,546,575	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	10,248,871	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	16,380,014	0	948	948	66.00	
69.00 06900 ELECTROCARDIOLOGY	51,702,969	0	210	210	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	628,670	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39,590,619	0	0	0	71.00	
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	66,635,909	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	69,028,133	0	0	0	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	1,416,975	0	8,939	8,939	88.00	
91.00 09100 EMERGENCY	38,304,776	0	2,387	2,387	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE					113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	826,005,854	100	25,899	25,899	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00	
192.01 19201 FAMILY PRACTICE	0	0	26,949	26,949	192.01	
192.02 19202 UNUSED SPACE	0	0	0	0	192.02	
200.00	Cross Foot Adjustments				200.00	
201.00	Negative Cost Centers				201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,027,939	0	1,729,476	1,426,402	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.001244	0.000000	32.725477	26.990652	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17,015	0	12,700	12,154	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000021	0.000000	0.240312	0.229980	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140164

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

Worksheet C  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	35,961,864	35,961,864	0	35,961,864	30.00
31.00	03100 INTENSIVE CARE UNIT	6,858,828	6,858,828	10,647	6,869,475	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	2,152,546	2,152,546	17,546	2,170,092	35.00
43.00	04300 NURSERY	303,295	303,295	0	303,295	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	20,753,119	20,753,119	0	20,753,119	50.00
50.01	05001 SAME DAY SURGERY	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	1,680,477	1,680,477	0	1,680,477	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,862,050	7,862,050	1,024	7,863,074	52.00
53.00	05300 ANESTHESIOLOGY	1,659,494	1,659,494	0	1,659,494	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,345,834	9,345,834	0	9,345,834	54.00
54.01	03480 ONCOLOGY	6,036,730	6,036,730	62,522	6,099,252	54.01
54.02	03440 MAMMOGRAPHY	2,603,582	2,603,582	7,507	2,611,089	54.02
56.00	05600 RADIOISOTOPE	2,321,740	2,321,740	0	2,321,740	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,848,551	1,848,551	0	1,848,551	58.00
59.00	05900 CARDIAC CATHETERIZATION	14,810,678	14,810,678	9,832	14,820,510	59.00
60.00	06000 LABORATORY	10,752,534	10,752,534	0	10,752,534	60.00
64.00	06400 INTRAVENOUS THERAPY	980,426	980,426	9,959	990,385	64.00
65.00	06500 RESPIRATORY THERAPY	2,581,190	2,581,190	0	2,581,190	65.00
66.00	06600 PHYSICAL THERAPY	5,090,454	5,090,454	0	5,090,454	66.00
69.00	06900 ELECTROCARDIOLOGY	10,817,530	10,817,530	0	10,817,530	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	317,173	317,173	1,652	318,825	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25,738,726	25,738,726	0	25,738,726	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,345,974	6,345,974	0	6,345,974	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,632,788	21,632,788	0	21,632,788	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	2,183,511	2,183,511	0	2,183,511	88.00
91.00	09100 EMERGENCY	8,499,755	8,499,755	5,704	8,505,459	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,291,892	4,291,892		4,291,892	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	213,430,741	213,430,741	126,393	213,557,134	200.00
201.00	Less Observation Beds	4,291,892	4,291,892		4,291,892	201.00
202.00	Total (see instructions)	209,138,849	209,138,849	126,393	209,265,242	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet C Part I Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	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					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	33,004,660		33,004,660		30.00
31.00	03100	INTENSIVE CARE UNIT	5,497,549		5,497,549		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	7,288,664		7,288,664		35.00
43.00	04300	NURSERY	1,826,429		1,826,429		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	70,843,953	50,087,879	120,931,832	0.171610	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0.000000	50.01
51.00	05100	RECOVERY ROOM	5,662,591	5,215,623	10,878,214	0.154481	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,047,270	4,379,614	15,426,884	0.509633	52.00
53.00	05300	ANESTHESIOLOGY	10,339,465	6,967,185	17,306,650	0.095888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,979,698	70,784,662	97,764,360	0.095596	54.00
54.01	03480	ONCOLOGY	153,832	40,778,890	40,932,722	0.147479	54.01
54.02	03440	MAMMOGRAPHY	1,960	8,490,195	8,492,155	0.306587	54.02
56.00	05600	RADIOISOTOPE	4,064,391	12,015,493	16,079,884	0.144388	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,346,533	15,893,330	19,239,863	0.096079	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,391,175	28,663,251	47,054,426	0.314756	59.00
60.00	06000	LABORATORY	33,519,466	40,917,667	74,437,133	0.144451	60.00
64.00	06400	INTRAVENOUS THERAPY	8,321	2,538,254	2,546,575	0.384998	64.00
65.00	06500	RESPIRATORY THERAPY	8,927,689	1,308,997	10,236,686	0.252151	65.00
66.00	06600	PHYSICAL THERAPY	3,936,406	12,037,176	15,973,582	0.318680	66.00
69.00	06900	ELECTROCARDIOLOGY	11,778,396	37,467,951	49,246,347	0.219662	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	304,098	322,046	626,144	0.506550	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,517,770	16,273,934	35,791,704	0.719125	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	33,046,714	33,355,318	66,402,032	0.095569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,015,960	37,114,863	72,130,823	0.299910	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	1,416,975	1,416,975		88.00
91.00	09100	EMERGENCY	7,416,884	30,559,333	37,976,217	0.223818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	976,509	5,800,588	6,777,097	0.633294	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	352,896,383	462,389,224	815,285,607		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	352,896,383	462,389,224	815,285,607		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet C Part I Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		35.00
43.00	04300	NURSERY		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0.171610	50.00
50.01	05001	SAME DAY SURGERY	0.000000	50.01
51.00	05100	RECOVERY ROOM	0.154481	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509699	52.00
53.00	05300	ANESTHESIOLOGY	0.095888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095596	54.00
54.01	03480	ONCOLOGY	0.149007	54.01
54.02	03440	MAMMOGRAPHY	0.307471	54.02
56.00	05600	RADIOISOTOPE	0.144388	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.096079	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.314965	59.00
60.00	06000	LABORATORY	0.144451	60.00
64.00	06400	INTRAVENOUS THERAPY	0.388909	64.00
65.00	06500	RESPIRATORY THERAPY	0.252151	65.00
66.00	06600	PHYSICAL THERAPY	0.318680	66.00
69.00	06900	ELECTROCARDIOLOGY	0.219662	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.509188	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.719125	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.095569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299910	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.223968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.633294	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140164

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

Worksheet C  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS		35,961,864	0	35,961,864	30.00	
31.00	03100 INTENSIVE CARE UNIT		6,858,828	10,647	6,869,475	31.00	
35.00	02060 NEONATAL INTENSIVE CARE UNIT		2,152,546	17,546	2,170,092	35.00	
43.00	04300 NURSERY		303,295	0	303,295	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM		20,753,119	0	20,753,119	50.00	
50.01	05001 SAME DAY SURGERY		0	0	0	50.01	
51.00	05100 RECOVERY ROOM		1,680,477	0	1,680,477	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,862,050	1,024	7,863,074	52.00	
53.00	05300 ANESTHESIOLOGY		1,659,494	0	1,659,494	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,345,834	0	9,345,834	54.00	
54.01	03480 ONCOLOGY		6,036,730	62,522	6,099,252	54.01	
54.02	03440 MAMMOGRAPHY		2,603,582	7,507	2,611,089	54.02	
56.00	05600 RADIOISOTOPE		2,321,740	0	2,321,740	56.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		1,848,551	0	1,848,551	58.00	
59.00	05900 CARDIAC CATHETERIZATION		14,810,678	9,832	14,820,510	59.00	
60.00	06000 LABORATORY		10,752,534	0	10,752,534	60.00	
64.00	06400 INTRAVENOUS THERAPY		980,426	9,959	990,385	64.00	
65.00	06500 RESPIRATORY THERAPY	0	2,581,190	0	2,581,190	65.00	
66.00	06600 PHYSICAL THERAPY	0	5,090,454	0	5,090,454	66.00	
69.00	06900 ELECTROCARDIOLOGY		10,817,530	0	10,817,530	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		317,173	1,652	318,825	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		25,738,726	0	25,738,726	71.00	
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS		6,345,974	0	6,345,974	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		21,632,788	0	21,632,788	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC		2,183,511	0	2,183,511	88.00	
91.00	09100 EMERGENCY		8,499,755	5,704	8,505,459	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4,291,892		4,291,892	92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		213,430,741	0	213,430,741	200.00	
201.00	Less Observation Beds		4,291,892		4,291,892	201.00	
202.00	Total (see instructions)		209,138,849	0	209,138,849	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140164

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

Worksheet C  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	33,004,660		33,004,660		30.00
31.00	03100	INTENSIVE CARE UNIT	5,497,549		5,497,549		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	7,288,664		7,288,664		35.00
43.00	04300	NURSERY	1,826,429		1,826,429		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	70,843,953	50,087,879	120,931,832	0.171610	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0.000000	50.01
51.00	05100	RECOVERY ROOM	5,662,591	5,215,623	10,878,214	0.154481	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,047,270	4,379,614	15,426,884	0.509633	52.00
53.00	05300	ANESTHESIOLOGY	10,339,465	6,967,185	17,306,650	0.095888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,979,698	70,784,662	97,764,360	0.095596	54.00
54.01	03480	ONCOLOGY	153,832	40,778,890	40,932,722	0.147479	54.01
54.02	03440	MAMMOGRAPHY	1,960	8,490,195	8,492,155	0.306587	54.02
56.00	05600	RADIOISOTOPE	4,064,391	12,015,493	16,079,884	0.144388	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,346,533	15,893,330	19,239,863	0.096079	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,391,175	28,663,251	47,054,426	0.314756	59.00
60.00	06000	LABORATORY	33,519,466	40,917,667	74,437,133	0.144451	60.00
64.00	06400	INTRAVENOUS THERAPY	8,321	2,538,254	2,546,575	0.384998	64.00
65.00	06500	RESPIRATORY THERAPY	8,927,689	1,308,997	10,236,686	0.252151	65.00
66.00	06600	PHYSICAL THERAPY	3,936,406	12,037,176	15,973,582	0.318680	66.00
69.00	06900	ELECTROCARDIOLOGY	11,778,396	37,467,951	49,246,347	0.219662	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	304,098	322,046	626,144	0.506550	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,517,770	16,273,934	35,791,704	0.719125	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	33,046,714	33,355,318	66,402,032	0.095569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,015,960	37,114,863	72,130,823	0.299910	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	1,416,975	1,416,975	1.540966	88.00
91.00	09100	EMERGENCY	7,416,884	30,559,333	37,976,217	0.223818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	976,509	5,800,588	6,777,097	0.633294	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	352,896,383	462,389,224	815,285,607		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	352,896,383	462,389,224	815,285,607		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet C Part I Date/Time Prepared: 8/29/2016 8:10 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
50.01	05001 SAME DAY SURGERY	0.000000		50.01
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
54.01	03480 ONCOLOGY	0.000000		54.01
54.02	03440 MAMMOGRAPHY	0.000000		54.02
56.00	05600 RADIOISOTOPE	0.000000		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140164		Period: From 04/01/2015 To 03/31/2016		Worksheet D Part I Date/Time Prepared: 8/29/2016 8:10 pm	
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)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,273,344	0	2,273,344	33,759	67.34	30.00
31.00	INTENSIVE CARE UNIT	460,488		460,488	3,849	119.64	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	183,934		183,934	1,751	105.05	35.00
43.00	NURSERY	28,329		28,329	3,059	9.26	43.00
200.00	Total (lines 30-199)	2,946,095		2,946,095	42,418		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	13,256	892,659				
31.00	INTENSIVE CARE UNIT	2,026	242,391				
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	15,282	1,135,050				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part II Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	3,270,244	120,931,832	0.027042	34,860,038	942,685	50.00
50.01	05001 SAME DAY SURGERY	0	0	0.000000	0	0	50.01
51.00	05100 RECOVERY ROOM	163,333	10,878,214	0.015015	2,417,642	36,301	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	446,012	15,426,884	0.028911	42,155	1,219	52.00
53.00	05300 ANESTHESIOLOGY	147,222	17,306,650	0.008507	4,199,770	35,727	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,774,843	97,764,360	0.018154	14,117,228	256,284	54.00
54.01	03480 ONCOLOGY	2,266,786	40,932,722	0.055378	82,157	4,550	54.01
54.02	03440 MAMMOGRAPHY	408,101	8,492,155	0.048056	0	0	54.02
56.00	05600 RADIOISOTOPE	133,641	16,079,884	0.008311	2,549,240	21,187	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	924,376	19,239,863	0.048045	1,514,365	72,758	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,531,216	47,054,426	0.032541	4,893,316	159,233	59.00
60.00	06000 LABORATORY	642,766	74,437,133	0.008635	17,170,907	148,271	60.00
64.00	06400 INTRAVENOUS THERAPY	107,634	2,546,575	0.042266	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	129,808	10,236,686	0.012681	5,025,166	63,724	65.00
66.00	06600 PHYSICAL THERAPY	112,891	15,973,582	0.007067	2,287,100	16,163	66.00
69.00	06900 ELECTROCARDIOLOGY	450,224	49,246,347	0.009142	6,437,200	58,849	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	84,240	626,144	0.134538	83,943	11,294	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	187,397	35,791,704	0.005236	7,837,248	41,036	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	51,828	66,402,032	0.000781	15,501,814	12,107	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	269,954	72,130,823	0.003743	17,247,623	64,558	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	29,538	1,416,975	0.020846	0	0	88.00
91.00	09100 EMERGENCY	665,103	37,976,217	0.017514	3,641,290	63,774	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	271,312	6,777,097	0.040034	546,884	21,894	92.00
200.00	Total (lines 50-199)	14,068,469	767,668,305		140,455,086	2,031,614	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part III Date/Time Prepared: 8/29/2016 8:10 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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	35.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	33,759	0.00	13,256	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,849	0.00	2,026	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	1,751	0.00	0	0	35.00
43.00	04300	NURSERY	3,059	0.00	0	0	43.00
200.00		Total (lines 30-199)	42,418		15,282	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
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0			35.00
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: 140164

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

Worksheet D  
Part IV  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
50.01	05001	SAME DAY SURGERY	0	0	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	03480	ONCOLOGY	0	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140164

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

Worksheet D  
Part IV  
Date/Time Prepared:  
8/29/2016 8:10 pm

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		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	120,931,832	0.000000	0.000000	34,860,038	50.00
50.01	05001	SAME DAY SURGERY	0	0	0.000000	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0	10,878,214	0.000000	0.000000	2,417,642	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,426,884	0.000000	0.000000	42,155	52.00
53.00	05300	ANESTHESIOLOGY	0	17,306,650	0.000000	0.000000	4,199,770	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,764,360	0.000000	0.000000	14,117,228	54.00
54.01	03480	ONCOLOGY	0	40,932,722	0.000000	0.000000	82,157	54.01
54.02	03440	MAMMOGRAPHY	0	8,492,155	0.000000	0.000000	0	54.02
56.00	05600	RADIOISOTOPE	0	16,079,884	0.000000	0.000000	2,549,240	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	19,239,863	0.000000	0.000000	1,514,365	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	47,054,426	0.000000	0.000000	4,893,316	59.00
60.00	06000	LABORATORY	0	74,437,133	0.000000	0.000000	17,170,907	60.00
64.00	06400	INTRAVENOUS THERAPY	0	2,546,575	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,236,686	0.000000	0.000000	5,025,166	65.00
66.00	06600	PHYSICAL THERAPY	0	15,973,582	0.000000	0.000000	2,287,100	66.00
69.00	06900	ELECTROCARDIOLOGY	0	49,246,347	0.000000	0.000000	6,437,200	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	626,144	0.000000	0.000000	83,943	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	35,791,704	0.000000	0.000000	7,837,248	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	66,402,032	0.000000	0.000000	15,501,814	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	72,130,823	0.000000	0.000000	17,247,623	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	1,416,975	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	37,976,217	0.000000	0.000000	3,641,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,777,097	0.000000	0.000000	546,884	92.00
200.00		Total (lines 50-199)	0	767,668,305			140,455,086	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140164

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

Worksheet D  
Part IV  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	17,625,817	0	0	0	50.00
50.01	05001 SAME DAY SURGERY	0	0	0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	3,299,181	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,782,334	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	18,556,210	0	0	0	54.00
54.01	03480 ONCOLOGY	0	17,322,892	0	0	0	54.01
54.02	03440 MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0	10,624,879	0	0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,488,750	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	10,027,423	0	0	0	59.00
60.00	06000 LABORATORY	0	7,940,490	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	381,919	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	23,660	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	7,942,401	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	45,254	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,593,873	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	17,275,446	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,621,960	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	6,198,031	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,877,539	0	0	0	92.00
200.00	Total (lines 50-199)	0	141,628,059	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140164

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

Worksheet D  
Part IV  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	0		50.00
50.01	05001	SAME DAY SURGERY	0	0		50.01
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
54.01	03480	ONCOLOGY	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part V Date/Time Prepared: 8/29/2016 8:10 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			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.171610	17,625,817	0	0	3,024,766	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0.154481	3,299,181	0	0	509,661	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509633	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.095888	1,782,334	0	0	170,904	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095596	18,556,210	0	0	1,773,899	54.00
54.01	03480	ONCOLOGY	0.147479	17,322,892	0	0	2,554,763	54.01
54.02	03440	MAMMOGRAPHY	0.306587	0	615	0	0	54.02
56.00	05600	RADIOISOTOPE	0.144388	10,624,879	0	0	1,534,105	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.096079	3,488,750	0	0	335,196	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.314756	10,027,423	0	0	3,156,192	59.00
60.00	06000	LABORATORY	0.144451	7,940,490	14,294	0	1,147,012	60.00
64.00	06400	INTRAVENOUS THERAPY	0.384998	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.252151	381,919	0	0	96,301	65.00
66.00	06600	PHYSICAL THERAPY	0.318680	23,660	0	0	7,540	66.00
69.00	06900	ELECTROCARDIOLOGY	0.219662	7,942,401	0	0	1,744,644	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.506550	45,254	0	0	22,923	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.719125	5,593,873	0	0	4,022,694	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.095569	17,275,446	0	0	1,650,997	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299910	11,621,960	0	44,012	3,485,542	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.223818	6,198,031	0	0	1,387,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.633294	1,877,539	0	0	1,189,034	92.00
200.00		Subtotal (see instructions)		141,628,059	14,909	44,012	27,813,404	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		141,628,059	14,909	44,012	27,813,404	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet D Part V Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	05001	SAME DAY SURGERY	0	0	50.01
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
54.01	03480	ONCOLOGY	0	0	54.01
54.02	03440	MAMMOGRAPHY	189	0	54.02
56.00	05600	RADIOISOTOPE	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	2,065	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,200	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	2,254	13,200	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	2,254	13,200	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 8/29/2016 8:10 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		33,759	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		33,759	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)		29,730	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)		13,256	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		35,961,864	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)		35,961,864	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		35,961,864	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,065.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,120,954	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)		14,120,954	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet D-1 Date/Time Prepared: 8/29/2016 8:10 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	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	6,869,475	3,849	1,784.74	2,026	3,615,883	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	NEONATAL INTENSIVE CARE UNIT	2,170,092	1,751	1,239.34	0	0	47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					29,581,719	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					47,318,556	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)					1,135,050	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,031,614	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,166,664	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					44,151,892	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)					4,029	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,065.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,291,892	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140164		Period: From 04/01/2015 To 03/31/2016		Worksheet D-1 Date/Time Prepared: 8/29/2016 8:10 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,273,344	35,961,864	0.063215	4,291,892	271,312	90.00
91.00	Nursing School cost	0	35,961,864	0.000000	4,291,892	0	91.00
92.00	Allied health cost	0	35,961,864	0.000000	4,291,892	0	92.00
93.00	All other Medical Education	0	35,961,864	0.000000	4,291,892	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet D-3 Date/Time Prepared: 8/29/2016 8:10 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		12,613,874	30.00
31.00	03100	INTENSIVE CARE UNIT		2,771,568	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.171610	34,860,038	50.00
50.01	05001	SAME DAY SURGERY	0.000000	0	50.01
51.00	05100	RECOVERY ROOM	0.154481	2,417,642	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.509699	42,155	52.00
53.00	05300	ANESTHESIOLOGY	0.095888	4,199,770	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095596	14,117,228	54.00
54.01	03480	ONCOLOGY	0.149007	82,157	54.01
54.02	03440	MAMMOGRAPHY	0.307471	0	54.02
56.00	05600	RADIOISOTOPE	0.144388	2,549,240	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.096079	1,514,365	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.314965	4,893,316	59.00
60.00	06000	LABORATORY	0.144451	17,170,907	60.00
64.00	06400	INTRAVENOUS THERAPY	0.388909	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.252151	5,025,166	65.00
66.00	06600	PHYSICAL THERAPY	0.318680	2,287,100	66.00
69.00	06900	ELECTROCARDIOLOGY	0.219662	6,437,200	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.509188	83,943	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.719125	7,837,248	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.095569	15,501,814	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.299910	17,247,623	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.223968	3,641,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.633294	546,884	92.00
200.00		Total (sum of lines 50-94 and 96-98)		140,455,086	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)		140,455,086	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		16,830,744	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		17,625,324	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)		727,380	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		5,494,578	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		155.21	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		5.17	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)		5.17	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		16.31	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)		5.17	12.00
13.00	Total allowable FTE count for the prior year.		5.17	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.		5.17	14.00
15.00	Sum of lines 12 through 14 divided by 3.		5.17	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		5.17	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.033310	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.032896	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.032896	21.00
22.00	IME payment adjustment (see instructions)		613,766	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		97,875	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		7.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		11.14	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)		7.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.045100	26.00
27.00	IME payments adjustment factor. (see instructions)		0.011897	27.00
28.00	IME add-on adjustment amount (see instructions)		409,924	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		65,369	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		1,023,690	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		163,244	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.83	31.00
32.00	Sum of lines 30 and 31		34.67	32.00
33.00	Allowable disproportionate share percentage (see instructions)		17.82	33.00
34.00	Disproportionate share adjustment (see instructions)		1,535,018	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/29/2016 8:10 pm	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,227,556	1,881,976	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,116,830	940,988	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,057,818		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		39,799,974		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				<b>Amount</b>	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			39,963,218	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			3,057,153	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).			375,220	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)			43,395,591	59.00
60.00	Primary payer payments			6,451	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			43,389,140	61.00
62.00	Deductibles billed to program beneficiaries			3,532,676	62.00
63.00	Coinurance billed to program beneficiaries			57,295	63.00
64.00	Allowable bad debts (see instructions)			975,890	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			634,329	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			729,658	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			40,433,498	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)			0	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part A Date/Time Prepared: 8/29/2016 8:10 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		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		40,433,498		71.00
71.01	Sequestration adjustment (see instructions)		808,670		71.01
72.00	Interim payments		39,865,679		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)		-240,851		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		80,051		75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)		0		100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
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
<b>HRR Adjustment for HSP Bonus Payment</b>					
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: 140164		Period: From 04/01/2015 To 03/31/2016		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 8/29/2016 8:10 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	
<b>CALCULATION OF THE DSH PAYMENT PERCENTAGE</b>							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	6.84	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	27.83	0.00			27.83	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	34.67	0.00			27.83	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	155.21	0.00			155.21	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	17.82	0.00			12.17	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)	6.84	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")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
<b>CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS</b>							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	8,178	0			8,178	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,537	0			1,537	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	345	0			345	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	1,055	0			1,055	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	11,115	0			11,115	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	38,389	0			38,389	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,551	0			1,551	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)	39,940	0			39,940	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	27.83	0.00			27.83	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140164		Period: From 04/01/2015 To 03/31/2016		Worksheet DSH Date/Time Prepared: 8/29/2016 8:10 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	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	17.82		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		17.82		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.		17.82		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	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: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet DSH Date/Time Prepared: 8/29/2016 8:10 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	12.17	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	12.17	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.	12.17	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet E Part B Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		15,454	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		27,813,404	2.00
3.00	PPS payments		23,677,033	3.00
4.00	Outlier payment (see instructions)		271,205	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.872	5.00
6.00	Line 2 times line 5		24,253,288	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		98.74	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)		15,454	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		58,921	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)		58,921	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		58,921	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		43,467	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)		15,454	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)		23,948,238	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		4,461,180	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)		19,502,512	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		222,599	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)		19,725,111	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		19,725,111	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,046,801	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		680,421	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		789,007	36.00
37.00	Subtotal (see instructions)		20,405,532	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)		20,405,532	40.00
40.01	Sequestration adjustment (see instructions)		408,111	40.01
41.00	Interim payments		20,234,709	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-237,288	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140164

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
8/29/2016 8:10 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		39,907,841		19,770,836	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	11/03/2015	184,735	11/03/2015	98,948	3.01	
3.02			0	03/24/2016	364,925	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	03/24/2016	226,897		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)		-42,162		463,873	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)		39,865,679		20,234,709	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		240,851		237,288	6.02	
7.00	Total Medicare program liability (see instructions)		39,624,828		19,997,421	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140164

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
8/29/2016 8:10 pm

		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			10,877 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			15,282 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			2,431 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			35,330 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			815,285,607 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			9,189,530 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)			1,000,407 8.00
9.00	Sequestration adjustment amount (see instructions)			20,008 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			980,399 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			979,540 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)			859 32.00
				Overrides
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0 108.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet E-4 Date/Time Prepared: 8/29/2016 8:10 pm	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			15.80	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			15.80	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			16.31	6.00
7.00	Enter the lesser of line 5 or line 6			15.80	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	16.31	0.00	16.31	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	15.80	0.00	15.80	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	15.80	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	15.80	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	15.80	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	15.80	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	15.80	0.00		17.00
18.00	Per resident amount	80,339.23	0.00		18.00
19.00	Approved amount for resident costs	1,269,360	0	1,269,360	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.51	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,269,360	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	15,282	2,431		26.00
27.00	Total Inpatient Days (see instructions)	36,881	36,881		27.00
28.00	Ratio of inpatient days to total inpatient days	0.414360	0.065915		28.00
29.00	Program direct GME amount	525,972	83,670		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		11,823		30.00
31.00	Net Program direct GME amount			597,819	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet E-4 Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		47,318,556	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		6,451	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		47,312,105	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		28,067,789	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		28,067,789	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		75,379,894	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.627649	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.372351	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		597,819	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		375,220	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		222,599	50.00

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

Provider CCN: 140164

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

Worksheet G

Date/Time Prepared:  
8/29/2016 8:10 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	5,285,053	0	23,370	0	1.00
2.00	Temporary investments	68,080	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	148,283,171	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-92,740,732	0	0	0	6.00
7.00	Inventory	6,817,139	0	0	0	7.00
8.00	Prepaid expenses	908,980	0	0	0	8.00
9.00	Other current assets	163,904	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)	68,785,595	0	23,370	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	6,880,998	0	0	0	12.00
13.00	Land improvements	5,719,624	0	0	0	13.00
14.00	Accumulated depreciation	-2,887,039	0	0	0	14.00
15.00	Buildings	149,512,576	0	0	0	15.00
16.00	Accumulated depreciation	-72,161,577	0	0	0	16.00
17.00	Leasehold improvements	192,105	0	0	0	17.00
18.00	Accumulated depreciation	-123,086	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	658,949	0	0	0	21.00
22.00	Accumulated depreciation	-315,632	0	0	0	22.00
23.00	Major movable equipment	71,169,728	0	0	0	23.00
24.00	Accumulated depreciation	-43,378,255	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	21,416,526	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	136,684,917	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	3,606,108	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	181,267	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,787,375	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	209,257,887	0	23,370	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	14,905,632	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,104,534	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,224,340	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	5,487,211	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	32,721,717	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	133,959,693	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,254,317	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	135,214,010	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	167,935,727	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	41,322,160	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	23,370	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	41,322,160	0	23,370	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	209,257,887	0	23,370	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140164

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

Worksheet G-1

Date/Time Prepared:  
8/29/2016 8:10 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		276,367,933			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-235,045,774				2.00
3.00	Total (sum of line 1 and line 2)		41,322,159			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	1		0		0	5.00
6.00	RESTRICTED GRANT ACTIVITY	0		0		5,709	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		0		10.00
11.00	Subtotal (line 3 plus line 10)		41,322,160			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		41,322,160			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	17,661		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)	17,661		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	ROUNDING		0				5.00
6.00	RESTRICTED GRANT ACTIVITY		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)	5,709		0			10.00
11.00	Subtotal (line 3 plus line 10)	23,370		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	23,370		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140164

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
8/29/2016 8:10 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	36,833,176		36,833,176	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	36,833,176		36,833,176	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,497,549		5,497,549	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	NEONATAL INTENSIVE CARE UNIT	7,291,495		7,291,495	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	12,789,044		12,789,044	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	49,622,220		49,622,220	17.00
18.00	Ancillary services	305,871,168	469,095,491	774,966,659	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	1,416,975	0	1,416,975	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	356,910,363	469,095,491	826,005,854	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		211,189,388		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)		211,189,388		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140164

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

Worksheet G-3

Date/Time Prepared:  
8/29/2016 8:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	826,005,854	1.00
2.00	Less contractual allowances and discounts on patients' accounts	567,776,306	2.00
3.00	Net patient revenues (line 1 minus line 2)	258,229,548	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	211,189,388	4.00
5.00	Net income from service to patients (line 3 minus line 4)	47,040,160	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	711,655	6.00
7.00	Income from investments	650,177	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	12,711	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	1,165,382	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	4,798	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	88,674	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	15,885	21.00
22.00	Rental of hospital space	843,225	22.00
23.00	Governmental appropriations	388,818	23.00
24.00	MISC./DEPARTMENTAL REVENUE	52,648	24.00
25.00	Total other income (sum of lines 6-24)	3,933,973	25.00
26.00	Total (line 5 plus line 25)	50,974,133	26.00
27.00	CORP ALLOC/CONTR/LOSS ON EQUIP	286,019,907	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	286,019,907	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-235,045,774	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet L Parts I-III Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		2,718,914	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		46,228	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)		100.77	3.00
4.00	Number of interns & residents (see instructions)		12.17	4.00
5.00	Indirect medical education percentage (see instructions)		3.47	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)		94,346	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		6.84	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		27.83	8.00
9.00	Sum of lines 7 and 8		34.67	9.00
10.00	Allowable disproportionate share percentage (see instructions)		7.27	10.00
11.00	Disproportionate share adjustment (see instructions)		197,665	11.00
12.00	Total prospective capital payments (see instructions)		3,057,153	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2015 To 03/31/2016	Worksheet M-1 Date/Time Prepared: 8/29/2016 8:10 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	115,001	0	115,001	0	115,001	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	36,723	0	36,723	0	36,723	9.00
10.00	Subtotal (sum of lines 1 through 9)	151,724	0	151,724	0	151,724	10.00
11.00	Physician Services Under Agreement	529,133	0	529,133	0	529,133	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	221,428	0	221,428	0	221,428	13.00
14.00	Subtotal (sum of lines 11 through 13)	750,561	0	750,561	0	750,561	14.00
15.00	Medical Supplies	0	116,510	116,510	-15,170	101,340	15.00
16.00	Transportation (Health Care Staff)	0	2,088	2,088	0	2,088	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	118,598	118,598	-15,170	103,428	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	902,285	118,598	1,020,883	-15,170	1,005,713	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	144,036	144,036	0	144,036	29.00
30.00	Administrative Costs	231,227	50,694	281,921	0	281,921	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	231,227	194,730	425,957	0	425,957	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,133,512	313,328	1,446,840	-15,170	1,431,670	32.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 140164  
Component CCN: 143454

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

Worksheet M-1  
Date/Time Prepared:  
8/29/2016 8:10 pm  
Rural Health Clinic (RHC) I  
Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	115,001	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	36,723	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	151,724	10.00
11.00	Physician Services Under Agreement	0	529,133	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	221,428	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	750,561	14.00
15.00	Medical Supplies	0	101,340	15.00
16.00	Transportation (Health Care Staff)	0	2,088	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	103,428	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,005,713	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
<b>FACILITY OVERHEAD</b>				
29.00	Facility Costs	0	144,036	29.00
30.00	Administrative Costs	-59,327	222,594	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-59,327	366,630	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-59,327	1,372,343	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2015 To 03/31/2016	Worksheet M-2 Date/Time Prepared: 8/29/2016 8:10 pm		
		Rural Health Clinic (RHC) I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.00	0		0	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.00	0		0	8.00
9.00	Physician Services Under Agreements		10,632			9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,005,713	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				1,005,713	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)				366,630	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				811,168	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,177,798	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtotal (see instructions)				1,177,798	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				1,177,798	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				2,183,511	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 140164	Period: From 04/01/2015 To 03/31/2016	Worksheet M-3	
		Component CCN: 143454		Date/Time Prepared: 8/29/2016 8:10 pm	
		Title XVIIII	Rural Health Clinic (RHC) I	Cost	
				1.00	
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>					
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,183,511		1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		49,343		2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,134,168		3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		0		4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		10,632		5.00
6.00	Total adjusted visits (line 4 plus line 5)		10,632		6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		200.73		7.00
			Calculation of Limit (1)		
			Prior to January 1	On or After January 1	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		80.44	81.32	8.00
9.00	Rate for Program covered visits (see instructions)		80.44	81.32	9.00
<b>CALCULATION OF SETTLEMENT</b>					
10.00	Program covered visits excluding mental health services (from contractor records)		2,110	851	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		169,728	69,203	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			238,931	16.00
16.01	Total program charges (see instructions)(from contractor's records)			0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			174,050	16.04
16.05	Total program cost (see instructions)			174,050	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			21,369	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			174,050	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			18,524	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			192,574	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
26.00	Net reimbursable amount (see instructions)			192,574	26.00
26.01	Sequestration adjustment (see instructions)			3,851	26.01
27.00	Interim payments			173,842	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)			14,881	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2015 To 03/31/2016	Worksheet M-4 Date/Time Prepared: 8/29/2016 8:10 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	151,724	151,724	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002358	0.007494	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	358	1,137	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	15,551	5,681	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	15,909	6,818	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,005,713	1,005,713	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,177,798	1,177,798	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015819	0.006779	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	18,632	7,984	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	34,541	14,802	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	118	375	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	292.72	39.47	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	44	143	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	12,880	5,644	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		49,343	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		18,524	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140164 Component CCN: 143454	Period: From 04/01/2015 To 03/31/2016	Worksheet M-5 Date/Time Prepared: 8/29/2016 8:10 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		169,733	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	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		11/03/2015	1,915	3.01
3.02		03/24/2016	2,194	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		4,109	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		173,842	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	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		14,881	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		188,723	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00