

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: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/22/2016 1:00 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/22/2016	Time: 1:00 pm
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 MEDICAL CENTER (140176) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
 ECR: Date: 11/22/2016 Time: 1:00 pm
 OyHv7asm: EpwuBYpg9JAZil92zf0b0
 tcPDT00AWZM4ycvBbz0rZjgNPq7.jt
 tyqa1elvn: 07902g
 PI: Date: 11/22/2016 Time: 1:00 pm
 iDhi eMfpZtjLr: Vw6RclujY1xG0o30
 n3Z5g0mjwQo3LASKWBkzHKAzD7n8wn
 lpSE0wMEc10AMMNx

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	105,570	88,892	-58,326	0	1.00
2.00 Subprovider - IPF	0	97,069	1		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	721	0		0	7.00
200.00 Total	0	203,360	88,893	-58,326	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 12:53 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 60098-		County: MCHENRY		1.00
1.00	Street: 3701 DOTY ROAD	2.00		3.00		4.00		5.00		2.00
2.00	City: WOODSTOCK									

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MEMORIAL MEDICAL CENTER	140176	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MMC INPATIENT PSYCHIATRY	14S176	16974	4	07/01/1992	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	MMC SKILLED NURSING FACILITY	145788	16974		11/22/1993	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			

20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					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.	346	239	3	0	1,162	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 12:53 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N		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		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		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		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)			N	0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00	2.00	3.00
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			Y	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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			V	XIX		
			1.00	2.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a critical access hospital (CAH)?		N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.		N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	
					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	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.		N		0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N			
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			
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	819,230	201,410	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			
119.00	DO NOT USE THIS LINE					
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	
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			
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			
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			
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.					
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.					
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.					
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.					
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.					
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.					
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.					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 12:53 pm			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00		
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H122		140.00		
		1.00	2.00	3.00			
141.00	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.						
	Name: NAME: CENTEGRA HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131	141.00		
142.00	Street: 385 MILLENNIUM DR.	PO Box:			142.00		
143.00	City: CRYSTAL LAKE	State: IL	Zip Code: 60012-3761		143.00		
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00		
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y			145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00		
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00		
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
155.00	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)	N	N	N	N		
156.00	Hospital	N	N	N	N		
157.00	Subprovider - IPF	N	N	N	N		
158.00	Subprovider - IRF	N	N	N	N		
159.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC	N	N	N	N		
					1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N		165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
							1.00
167.00	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 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)						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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 12:53 pm	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		04/01/2015	06/30/2015	170.00
			1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, 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: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 12:53 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/27/2016	Y	10/27/2016
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 12:53 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANNA	BURACKER		41.00
42.00	Enter the employer/company name of the cost report preparer.	CENTEGRA HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(815)759-8037	ABURACKER@CENTEGRA.COM		43.00

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

VOLUNTARY CONTACT INFORMATION	Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part V Date/Time Prepared: 11/22/2016 12:53 pm
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		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	ANNA	1.00
2.00	Last Name	BURACKER	2.00
3.00	Title	SR. REIMBURSEMENT ANALYST	3.00
4.00	Employer	CENTEGRA HEALTH SYSTEM	4.00
5.00	Phone Number	(815)759-8037	5.00
6.00	E-mail Address	ABURACKER@CENTEGRA.COM	6.00
7.00	Department	FINANCE	7.00
8.00	Mailing Address 1	527 W. SOUTH ST.	8.00
9.00	Mailing Address 2		9.00
10.00	City	WOODSTOCK	10.00
11.00	State	IL	11.00
12.00	Zip	60098	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	DAVID	13.00
14.00	Last Name	TOMLINSON	14.00
15.00	Title	EXECUTIVE VP & CFO	15.00
16.00	Employer	CENTEGRA HEALTH SYSTEM	16.00
17.00	Phone Number	(815)788-5800	17.00
18.00	E-mail Address	DTOMLINSON@CENTEGRA.COM	18.00
19.00	Department	ADMINISTRATION	19.00
20.00	Mailing Address 1	385 MILLENNIUM DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	CRYSTAL LAKE	22.00
23.00	State	IL	23.00
24.00	Zip	60012	24.00

HFS Supplemental Information		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part IX Date/Time Prepared: 11/22/2016 12:53 pm
		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140176

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2016 12:53 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	60	21,960	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)		60	21,960	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		72	26,352	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	32	11,712		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		104				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140176

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,596	297	11,912			1.00
2.00 HMO and other (see instructions)	835	1,408				2.00
3.00 HMO IPF Subprovider	208	2,558				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,596	297	11,912			7.00
8.00 INTENSIVE CARE UNIT	1,156	67	2,165			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	7,752	364	14,077	0.00	550.68	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,386	906	8,262	0.00	39.33	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	590.01	27.00
28.00 Observation Bed Days		51	2,179			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140176

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

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2016 12:53 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	1,927	60	3,807	1.00
2.00 HMO and other (see instructions)			178	387		2.00
3.00 HMO IPF Subprovider				434		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,927	60	3,807	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	319	84	1,303	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						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: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part II Date/Time Prepared: 11/22/2016 12:53 pm
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	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	47,184,224	-8,209,489	38,974,735	1,227,216.00	31.76	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		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,386,961	637,208	5,024,169	144,460.00	34.78	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		1,561,884	0	1,561,884	39,812.00	39.23	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		254,812	0	254,812	3,304.00	77.12	13.00
14.00	Home office salaries & wage-related costs		12,722,344	0	12,722,344	216,772.00	58.69	14.00
15.00	Home office: Physician Part A - Administrative		15,837	0	15,837	174.00	91.02	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		9,525,967	0	9,525,967			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,319,330	0	1,319,330			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	471,069	-471,069	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	11,842,892	-9,784,057	2,058,835	95,126.00	21.64	27.00
28.00	Administrative & General under contract (see inst.)		1,380,508	0	1,380,508	35,040.00	39.40	28.00
29.00	Maintenance & Repairs	6.00	647,633	9,965	657,598	22,348.00	29.43	29.00
30.00	Operation of Plant	7.00	1,068,899	12,170	1,081,069	53,494.00	20.21	30.00
31.00	Laundry & Linen Service	8.00	52,607	328	52,935	2,323.00	22.79	31.00
32.00	Housekeeping	9.00	1,004,751	11,142	1,015,893	63,144.00	16.09	32.00
33.00	Housekeeping under contract (see instructions)		141,114	0	141,114	4,234.00	33.33	33.00
34.00	Dietary	10.00	1,048,277	-542,664	505,613	31,774.00	15.91	34.00
35.00	Dietary under contract (see instructions)		133,608	0	133,608	5,768.00	23.16	35.00
36.00	Cafeteria	11.00	0	552,310	552,310	30,381.00	18.18	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,293,413	9,637	1,303,050	29,554.00	44.09	38.00
39.00	Central Services and Supply	14.00	334,795	2,941	337,736	17,798.00	18.98	39.00
40.00	Pharmacy	15.00	2,831,289	32,698	2,863,987	63,664.00	44.99	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140176

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

Worksheet S-3
Part II
Date/Time Prepared:
11/22/2016 12:53 pm

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140176

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

Worksheet S-3
Part III
Date/Time Prepared:
11/22/2016 12:53 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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	48,839,454	-8,209,489	40,629,965	1,272,258.00	31.94	1.00
2.00	Excluded area salaries (see instructions)	4,386,961	637,208	5,024,169	144,460.00	34.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)	44,452,493	-8,846,697	35,605,796	1,127,798.00	31.57	3.00
4.00	Subtotal other wages & related costs (see inst.)	14,554,877	0	14,554,877	260,062.00	55.97	4.00
5.00	Subtotal wage-related costs (see inst.)	9,525,967	0	9,525,967	0.00	26.75	5.00
6.00	Total (sum of lines 3 thru 5)	68,533,337	-8,846,697	59,686,640	1,387,860.00	43.01	6.00
7.00	Total overhead cost (see instructions)	22,250,855	-10,166,599	12,084,256	454,648.00	26.58	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 11/22/2016 12:53 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		920,354	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		16,405	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		5,787,691	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		217,199	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		112,180	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)		444,196	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		400,125	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,764,577	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		44,670	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		137,900	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		10,845,297	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part V Date/Time Prepared: 11/22/2016 12:53 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		1,561,884	0 1.00
2.00	Hospital		1,561,884	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF			0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF			0 9.00
10.00	Hospital-Based OLTC			0 10.00
11.00	Hospital-Based HHA			0 11.00
12.00	Separately Certified ASC			0 12.00
13.00	Hospital-Based Hospice			0 13.00
14.00	Hospital-Based Health Clinic RHC			0 14.00
15.00	Hospital-Based Health Clinic FQHC			0 15.00
16.00	Hospital-Based-CMHC			0 16.00
17.00	Renal Dialysis			0 17.00
18.00	Other		0	0 18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140176

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

Worksheet S-7

Date/Time Prepared:
11/22/2016 12:53 pm

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

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140176

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

Worksheet S-7

Date/Time Prepared:
11/22/2016 12:53 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 11/22/2016 12:53 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.283756	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		8,205,007	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		65,132	5.00	
6.00	Medicaid charges		57,684,033	6.00	
7.00	Medicaid cost (line 1 times line 6)		16,368,190	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)		8,098,051	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		8,098,051	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,977,296	1,197,344	5,174,640	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,128,582	339,754	1,468,336	21.00
22.00	Partial payment by patients approved for charity care	78,855	73,487	152,342	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,049,727	266,267	1,315,994	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)			5,033,004	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			669,326	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			4,363,678	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,238,220	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,554,214	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			10,652,265	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140176

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

Worksheet A

Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT		16,063,737	16,063,737	-11,268,277	4,795,460	1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	0	4,321,364	4,321,364	2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	471,069	10,317,099	10,788,168	-255,926	10,532,242	4.00	
5.00 00500 ADMINI STRATIVE & GENERAL	11,842,892	16,038,689	27,881,581	5,131,561	33,013,142	5.00	
6.00 00600 MAINTENANCE & REPAIRS	647,633	908,257	1,555,890	9,965	1,565,855	6.00	
7.00 00700 OPERATION OF PLANT	1,068,899	1,312,395	2,381,294	12,170	2,393,464	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	52,607	382,787	435,394	328	435,722	8.00	
9.00 00900 HOUSEKEEPING	1,004,751	674,545	1,679,296	11,142	1,690,438	9.00	
10.00 01000 DIETARY	1,048,277	1,108,981	2,157,258	-1,029,160	1,128,098	10.00	
11.00 01100 CAFETERIA	0	0	0	1,038,806	1,038,806	11.00	
13.00 01300 NURSING ADMINISTRATION	1,293,413	128,648	1,422,061	-76,045	1,346,016	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	334,795	1,049,317	1,384,112	-73,273	1,310,839	14.00	
15.00 01500 PHARMACY	2,831,289	6,783,816	9,615,105	-6,116,686	3,498,419	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1,669	1,669	0	1,669	16.00	
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	5,909,680	775,901	6,685,581	894,108	7,579,689	30.00	
31.00 03100 INTENSIVE CARE UNIT	1,720,967	363,867	2,084,834	112,575	2,197,409	31.00	
40.00 04000 SUBPROVIDER - I/PF	2,871,324	150,774	3,022,098	633,173	3,655,271	40.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
44.00 04400 SKILLED NURSING FACILITY	0	2,292	2,292	-2,292	0	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	4,474,081	8,706,324	13,180,405	-5,856,458	7,323,947	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	18,142	234,705	252,847	-3,446	249,401	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,882,194	842,661	2,724,855	-63,103	2,661,752	54.00	
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00	
56.00 05600 RADIOISOTOPE	272,490	290,547	563,037	3,846	566,883	56.00	
57.00 05700 CT SCAN	566,212	349,368	915,580	-8,337	907,243	57.00	
58.00 05800 MRI	235,210	147,646	382,856	3,125	385,981	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	198	2,460,112	2,460,310	-45,809	2,414,501	60.00	
65.00 06500 RESPIRATORY THERAPY	750,984	239,959	990,943	-14,534	976,409	65.00	
66.00 06600 PHYSICAL THERAPY	367,329	11,857	379,186	4,897	384,083	66.00	
67.00 06700 OCCUPATIONAL THERAPY	91,883	932	92,815	878	93,693	67.00	
68.00 06800 SPEECH PATHOLOGY	63,633	1,700	65,333	1,257	66,590	68.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
70.01 07001 SLEEP LAB/NEUROLOGY	756,643	209,517	966,160	11,972	978,132	70.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,813,564	4,813,564	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,026,989	2,026,989	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	6,062,817	6,062,817	73.00	
76.00 03140 CARDIOLOGY	259,033	25,264	284,297	3,395	287,692	76.00	
76.01 03950 WOUND CARE	756,526	1,287,427	2,043,953	-594,661	1,449,292	76.01	
76.97 07697 CARDIAC REHABILITATION	301,889	15,220	317,109	4,648	321,757	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	283,678	283,678	76.98	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 09001 WOMENS CENTER	0	0	0	0	0	90.01	
90.02 09002 PSYCH SERVICES	0	0	0	0	0	90.02	
90.03 09003 OP BEHAVIORAL HEALTH	756,493	54,273	810,766	10,473	821,239	90.03	
90.04 09004 DIABETES CENTER	0	0	0	0	0	90.04	
91.00 09100 EMERGENCY	3,018,051	1,141,094	4,159,145	-417	4,158,728	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE		0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	45,668,587	72,081,380	117,749,967	-11,693	117,738,274	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00	
190.02 19002 CRISIS PROGRAM	1,515,637	45,726	1,561,363	11,693	1,573,056	190.02	
191.00 19100 RESEARCH	0	0	0	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
200.00	TOTAL (SUM OF LINES 118-199)	47,184,224	72,127,106	119,311,330	0	119,311,330	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140176

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

Worksheet A
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,018,571	2,776,889	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-8,442	4,312,922	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-8,297	10,523,945	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,789,725	19,223,417	5.00
6.00	00600	MAINTENANCE & REPAIRS	-38,173	1,527,682	6.00
7.00	00700	OPERATION OF PLANT	-178,863	2,214,601	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	435,722	8.00
9.00	00900	HOUSEKEEPING	-99,760	1,590,678	9.00
10.00	01000	DIETARY	0	1,128,098	10.00
11.00	01100	CAFETERIA	-556,123	482,683	11.00
13.00	01300	NURSING ADMINISTRATION	377,540	1,723,556	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,310,839	14.00
15.00	01500	PHARMACY	-1,456,595	2,041,824	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,507,786	1,509,455	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-26	7,579,663	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,197,409	31.00
40.00	04000	SUBPROVIDER - IPF	-79,827	3,575,444	40.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-27,473	7,296,474	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	249,401	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-18,143	2,643,609	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	566,883	56.00
57.00	05700	CT SCAN	0	907,243	57.00
58.00	05800	MRI	0	385,981	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	2,414,501	60.00
65.00	06500	RESPIRATORY THERAPY	-57,000	919,409	65.00
66.00	06600	PHYSICAL THERAPY	-7,475	376,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	93,693	67.00
68.00	06800	SPEECH PATHOLOGY	0	66,590	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	-10,348	967,784	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,813,564	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,026,989	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,062,817	73.00
76.00	03140	CARDIOLOGY	0	287,692	76.00
76.01	03950	WOUND CARE	-62,966	1,386,326	76.01
76.97	07697	CARDIAC REHABILITATION	251	322,008	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-16,206	267,472	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	-11,620	809,619	90.03
90.04	09004	DIABETES CENTER	0	0	90.04
91.00	09100	EMERGENCY	-220,357	3,938,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-16,780,413	100,957,861	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.02	19002	CRISIS PROGRAM	0	1,573,056	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-16,780,413	102,530,917	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 140176

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

Worksheet Non-CMS W
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
7.00 OPERATION OF PLANT	00700		7.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
43.00 NURSERY	04300		43.00
44.00 SKILLED NURSING FACILITY	04400		44.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00 RADIOLOGY - THERAPEUTIC	05500		55.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MRI	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
70.01 SLEEP LAB/NEUROLOGY	07001		70.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
76.00 RADIOLOGY	03140	CARDIOLOGY	76.00
76.01 WOUND CARE	03950		76.01
76.97 CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
76.98 HYPERBARIC OXYGEN THERAPY	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
90.01 WOMENS CENTER	09001		90.01
90.02 PSYCH SERVICES	09002		90.02
90.03 OP BEHAVIORAL HEALTH	09003		90.03
90.04 DIABETES CENTER	09004		90.04
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.02 CRISIS PROGRAM	19002		190.02
191.00 RESEARCH	19100		191.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140176

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

Worksheet A-6
Date/Time Prepared:
11/22/2016 12:53 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - EQUIPMENT DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,148,195	1.00	
	TOTALS		0	4,148,195		
B - EQUIPMENT INTEREST						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	173,169	1.00	
	TOTALS		0	173,169		
C - NON-CAPITAL RELATED COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	231,003	1.00	
	TOTALS		0	231,003		
D - NON-CAPITAL INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,313,245	1.00	
	TOTALS		0	1,313,245		
E - WORKERS COMP INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	215,143	1.00	
	TOTALS		0	215,143		
F - PROVIDER TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,649,528	1.00	
	TOTALS		0	5,649,528		
H - CHARGABLE DRUG COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,062,817	1.00	
	TOTALS		0	6,062,817		
I - MED SUPPLIES & IMPLANTS						
1.00	SLEEP LAB/NEUROLOGY	70.01	0	1,857	1.00	
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,813,564	2.00	
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,026,989	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	
	0		0	6,842,410		
J - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	552,310	486,496	1.00	
	TOTALS		552,310	486,496		
K - ATO RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	40,364	0	1.00	
2.00	MAINTENANCE & REPAIRS	6.00	9,965	0	2.00	
3.00	OPERATION OF PLANT	7.00	12,170	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	328	0	4.00	
5.00	HOUSEKEEPING	9.00	11,142	0	5.00	
6.00	DIETARY	10.00	9,646	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	9,637	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	2,941	0	8.00	
9.00	PHARMACY	15.00	32,698	0	9.00	
10.00	ADULTS & PEDIATRICS	30.00	76,506	0	10.00	
11.00	INTENSIVE CARE UNIT	31.00	26,273	0	11.00	
12.00	SUBPROVIDER - IPF	40.00	28,154	0	12.00	
13.00	OPERATING ROOM	50.00	67,833	0	13.00	
14.00	ANESTHESIOLOGY	53.00	87	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	25,044	0	15.00	
16.00	RADIOISOTOPE	56.00	3,971	0	16.00	
17.00	CT SCAN	57.00	7,898	0	17.00	
18.00	MRI	58.00	3,496	0	18.00	
19.00	RESPIRATORY THERAPY	65.00	9,981	0	19.00	
20.00	PHYSICAL THERAPY	66.00	4,928	0	20.00	
21.00	OCCUPATIONAL THERAPY	67.00	1,122	0	21.00	
22.00	SPEECH PATHOLOGY	68.00	1,257	0	22.00	
23.00	SLEEP LAB/NEUROLOGY	70.01	10,115	0	23.00	

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
24.00	CARDIOLOGY	76.00	3,545	0	24.00
25.00	WOUND CARE	76.01	11,861	0	25.00
26.00	CARDIAC REHABILITATION	76.97	4,821	0	26.00
27.00	OP BEHAVIORAL HEALTH	90.03	10,473	0	27.00
28.00	EMERGENCY	91.00	33,036	0	28.00
29.00	CRISIS PROGRAM	190.02	11,777	0	29.00
			471,069	0	
L - CENTEGRA ALLOCATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,169,401	1.00
	TOTALS		0	8,169,401	
N - CASE MANAGEMENT/SOCIAL SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	861,143	11,550	1.00
2.00	INTENSIVE CARE UNIT	31.00	156,512	2,099	2.00
3.00	SUBPROVIDER - IPF	40.00	597,277	8,011	3.00
			1,614,932	21,660	
P - HYPERBARIC COSTS					
1.00	HYPERBARIC OXYGEN THERAPY	76.98	114,782	168,896	1.00
			114,782	168,896	
R - SALARY RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,088	1.00
			0	40,088	
S - SNF COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	2,292	1.00
	TOTALS		0	2,292	
500.00	Grand Total: Increases		2,753,093	33,524,343	500.00

RECLASSIFICATIONS

Provider CCN: 140176

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

Worksheet A-6
Date/Time Prepared:
11/22/2016 12:53 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - EQUIPMENT DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,148,195	9		1.00
	TOTALS		0	4,148,195			
B - EQUIPMENT INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	173,169	11		1.00
	TOTALS		0	173,169			
C - NON-CAPITAL RELATED COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	231,003	14		1.00
	TOTALS		0	231,003			
D - NON-CAPITAL INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,313,245	12		1.00
	TOTALS		0	1,313,245			
E - WORKERS COMP INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	215,143	12		1.00
	TOTALS		0	215,143			
F - PROVIDER TAX							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,649,528	13		1.00
	TOTALS		0	5,649,528			
H - CHARGABLE DRUG COSTS							
1.00	PHARMACY	15.00	0	6,062,817	0		1.00
	TOTALS		0	6,062,817			
I - MED SUPPLIES & IMPLANTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,981	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	85,682	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	76,214	0		3.00
4.00	PHARMACY	15.00	0	86,567	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	57,383	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	72,309	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	269	0		7.00
8.00	OPERATING ROOM	50.00	0	5,924,291	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	3,533	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	88,147	0		10.00
11.00	RADIOISOTOPE	56.00	0	125	0		11.00
12.00	CT SCAN	57.00	0	16,235	0		12.00
13.00	MRI	58.00	0	371	0		13.00
14.00	LABORATORY	60.00	0	45,809	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	24,515	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	31	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	244	0		17.00
18.00	CARDIOLOGY	76.00	0	150	0		18.00
19.00	WOUND CARE	76.01	0	322,844	0		19.00
20.00	CARDIAC REHABILITATION	76.97	0	173	0		20.00
21.00	EMERGENCY	91.00	0	33,453	0		21.00
22.00	CRISIS PRGRAM	190.02	0	84	0		22.00
	0		0	6,842,410			
J - CAFETERIA RECLASS							
1.00	DIETARY	10.00	552,310	486,496	0		1.00
	TOTALS		552,310	486,496			
K - ATO RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	471,069	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
26.00		0.00	0	0	0	0	26.00
27.00		0.00	0	0	0	0	27.00
28.00		0.00	0	0	0	0	28.00
29.00		0.00	0	0	0	0	29.00
			471,069		0		
L - CENTEGRA ALLOCATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	8,169,401	0	0	0	1.00
	TOTALS		8,169,401	0	0	0	
N - CASE MANAGEMENT/SOCIAL SERVICES							
1.00	ADMINISTRATIVE & GENERAL	5.00	1,614,932	21,660	0	0	1.00
2.00		0.00	0	0	0	0	2.00
3.00		0.00	0	0	0	0	3.00
			1,614,932	21,660			
P - HYPERBARIC COSTS							
1.00	WOUND CARE	76.01	114,782	168,896	0	0	1.00
			114,782	168,896			
R - SALARY RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	40,088	0	0	0	1.00
			40,088	0			
S - SNF COSTS							
1.00	SKILLED NURSING FACILITY	44.00	0	2,292	0	0	1.00
	TOTALS		0	2,292			
500.00	Grand Total: Decreases		10,962,582	25,314,854			500.00

RECLASSIFICATIONS

Provider CCN: 140176

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/22/2016 12:53 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		
A - EQUIPMENT DEPRECIATION									
1.00	CAP REL COSTS-MVBLE	2.00	0	4,148,195	CAP REL COSTS-BLDG & FIXT	1.00	0	4,148,195	1.00
	EQUIP								
	TOTALS		0	4,148,195	TOTALS		0	4,148,195	
B - EQUIPMENT INTEREST									
1.00	CAP REL COSTS-MVBLE	2.00	0	173,169	CAP REL COSTS-BLDG & FIXT	1.00	0	173,169	1.00
	EQUIP								
	TOTALS		0	173,169	TOTALS		0	173,169	
C - NON-CAPITAL RELATED COSTS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	231,003	ADMINISTRATIVE & GENERAL	5.00	0	231,003	1.00
	TOTALS		0	231,003	TOTALS		0	231,003	
D - NON-CAPITAL INSURANCE									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,313,245	CAP REL COSTS-BLDG & FIXT	1.00	0	1,313,245	1.00
	TOTALS		0	1,313,245	TOTALS		0	1,313,245	
E - WORKERS COMP INSURANCE									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	215,143	CAP REL COSTS-BLDG & FIXT	1.00	0	215,143	1.00
	TOTALS		0	215,143	TOTALS		0	215,143	
F - PROVIDER TAX									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,649,528	CAP REL COSTS-BLDG & FIXT	1.00	0	5,649,528	1.00
	TOTALS		0	5,649,528	TOTALS		0	5,649,528	
H - CHARGABLE DRUG COSTS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,062,817	PHARMACY	15.00	0	6,062,817	1.00
	TOTALS		0	6,062,817	TOTALS		0	6,062,817	
I - MED SUPPLIES & IMPLANTS									
1.00	SLEEP LAB/NEUROLOGY	70.01	0	1,857	ADMINISTRATIVE & GENERAL	5.00	0	3,981	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,813,564	NURSING	13.00	0	85,682	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,026,989	ADMINISTRATION		0	76,214	3.00
4.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	86,567	4.00
5.00		0.00	0	0	PHARMACY	15.00	0	57,383	5.00
6.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	72,309	6.00
7.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	269	7.00
8.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	5,924,291	8.00
9.00		0.00	0	0	OPERATING ROOM	50.00	0	3,533	9.00
10.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	88,147	10.00
11.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	125	11.00
12.00		0.00	0	0	RADIOISOTOPE	56.00	0	16,235	12.00
13.00		0.00	0	0	CT SCAN	57.00	0	371	13.00
14.00		0.00	0	0	MRI	58.00	0	45,809	14.00
15.00		0.00	0	0	LABORATORY	60.00	0	24,515	15.00
16.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	31	16.00
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	244	17.00
18.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	150	18.00
19.00		0.00	0	0	CARDIOLOGY	76.00	0	322,844	19.00
20.00		0.00	0	0	WOUND CARE	76.01	0	173	20.00
21.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	33,453	21.00
22.00		0.00	0	0	EMERGENCY	91.00	0	84	22.00
		0.00	0	0	CRISIS PROGRAM	190.02	0	6,842,410	
	0		0	6,842,410	0		0	6,842,410	
J - CAFETERIA RECLASS									
1.00	CAFETERIA	11.00	552,310	486,496	DIETARY	10.00	552,310	486,496	1.00
	TOTALS		552,310	486,496	TOTALS		552,310	486,496	
K - ATO RECLASS									
1.00	ADMINISTRATIVE & GENERAL	5.00	40,364	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	471,069	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	9,965	0		0.00	0	0	2.00
3.00	OPERATION OF PLANT	7.00	12,170	0		0.00	0	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	328	0		0.00	0	0	4.00
5.00	HOUSEKEEPING	9.00	11,142	0		0.00	0	0	5.00
6.00	DIETARY	10.00	9,646	0		0.00	0	0	6.00
7.00	NURSING	13.00	9,637	0		0.00	0	0	7.00
8.00	ADMINISTRATIVE & GENERAL	14.00	2,941	0		0.00	0	0	8.00
9.00	PHARMACY	15.00	32,698	0		0.00	0	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	76,506	0		0.00	0	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	26,273	0		0.00	0	0	11.00

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	
12.00	SUBPROVIDER - IPF	40.00	28,154	0		0.00	0	0	12.00
13.00	OPERATING ROOM	50.00	67,833	0		0.00	0	0	13.00
14.00	ANESTHESIOLOGY	53.00	87	0		0.00	0	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	25,044	0		0.00	0	0	15.00
16.00	RADIOISOTOPE	56.00	3,971	0		0.00	0	0	16.00
17.00	CT SCAN	57.00	7,898	0		0.00	0	0	17.00
18.00	MRI	58.00	3,496	0		0.00	0	0	18.00
19.00	RESPIRATORY THERAPY	65.00	9,981	0		0.00	0	0	19.00
20.00	PHYSICAL THERAPY	66.00	4,928	0		0.00	0	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	1,122	0		0.00	0	0	21.00
22.00	SPEECH PATHOLOGY	68.00	1,257	0		0.00	0	0	22.00
23.00	SLEEP LAB/NEUROLOGY	70.01	10,115	0		0.00	0	0	23.00
24.00	CARDIOLOGY	76.00	3,545	0		0.00	0	0	24.00
25.00	WOUND CARE	76.01	11,861	0		0.00	0	0	25.00
26.00	CARDIAC REHABILITATION	76.97	4,821	0		0.00	0	0	26.00
27.00	OP BEHAVIORAL HEALTH	90.03	10,473	0		0.00	0	0	27.00
28.00	EMERGENCY	91.00	33,036	0		0.00	0	0	28.00
29.00	CRISIS PROGRAM	190.02	11,777	0		0.00	0	0	29.00
			471,069	0			471,069	0	
L - CENTEGRA ALLOCATION									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,169,401	ADMINISTRATIVE & GENERAL	5.00	8,169,401	0	1.00
	TOTALS		0	8,169,401	TOTALS		8,169,401	0	
N - CASE MANAGEMENT/SOCIAL SERVICES									
1.00	ADULTS & PEDIATRICS	30.00	861,143	11,550	ADMINISTRATIVE & GENERAL	5.00	1,614,932	21,660	1.00
2.00	INTENSIVE CARE UNIT	31.00	156,512	2,099		0.00	0	0	2.00
3.00	SUBPROVIDER - IPF	40.00	597,277	8,011		0.00	0	0	3.00
			1,614,932	21,660			1,614,932	21,660	
P - HYPERBARIC COSTS									
1.00	HYPERBARIC OXYGEN THERAPY	76.98	114,782	168,896	WOUND CARE	76.01	114,782	168,896	1.00
			114,782	168,896			114,782	168,896	
R - SALARY RECLASS									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,088	ADMINISTRATIVE & GENERAL	5.00	40,088	0	1.00
			0	40,088			40,088	0	
S - SNF COSTS									
1.00	ADULTS & PEDIATRICS	30.00	0	2,292	SKILLED NURSING FACILITY	44.00	0	2,292	1.00
	TOTALS		0	2,292	TOTALS		0	2,292	
500.00	Grand Total: Increases		2,753,093	33,524,343	Grand Total: Decreases		10,962,582	25,314,854	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140176

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

Worksheet A-7
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	219,885	0	0	0	0	1.00
2.00	Land Improvements	3,212,830	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	75,585,445	125,942	0	125,942	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	54,421,409	2,197,305	0	2,197,305	0	6.00
7.00	HIT designated Assets	9,071,668	264,983	0	264,983	0	7.00
8.00	Subtotal (sum of lines 1-7)	142,511,237	2,588,230	0	2,588,230	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	142,511,237	2,588,230	0	2,588,230	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	219,885	0				1.00
2.00	Land Improvements	3,212,830	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	75,711,387	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	56,618,714	0				6.00
7.00	HIT designated Assets	9,336,651	0				7.00
8.00	Subtotal (sum of lines 1-7)	145,099,467	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	145,099,467	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140176

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

Worksheet A-7
Part II
Date/Time Prepared:
11/22/2016 12:53 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	16,063,737	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	16,063,737	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	16,063,737				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	16,063,737				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140176

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

Worksheet A-7
Part III
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	79,144,446	0	79,144,446	0.545450	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	65,955,021	0	65,955,021	0.454550	0	2.00
3.00	Total (sum of lines 1-2)	145,099,467	0	145,099,467	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	11,915,542	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,139,753	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,055,295	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	-2,191,740	-1,528,388	-5,649,528	231,003	2,776,889	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	173,169	0	0	0	4,312,922	2.00
3.00	Total (sum of lines 1-2)	-2,018,571	-1,528,388	-5,649,528	231,003	7,089,811	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,550,880	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-175,439	OPERATION OF PLANT		7.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-643,830				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	-5,709,648				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-544,013	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	-1,177	MEDICAL RECORDS & LIBRARY		16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 MEDICAL STAFF	B	-8,313	ADMINISTRATIVE & GENERAL		5.00	0 33.00
34.00 EDUCATION INCOME	B	-4,865	NURSING ADMINISTRATION		13.00	0 34.00

Provider CCN: 140176

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

Worksheet A-8

Date/Time Prepared:
 11/22/2016 12:53 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
35.00 EDUCATION INCOME	B	-19,014	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 MISCELLANEOUS INCOME	B	-251,997	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 OB EDUCATION	B	-26	ADULTS & PEDIATRICS	30.00	0	37.00
38.00 EMS TUITION	B	-45	EMERGENCY	91.00	0	38.00
39.00 OTHER INCOME	B	-900	PHARMACY	15.00	0	39.00
40.00 PHARMACY RETAIL INCOME	B	-1,455,695	PHARMACY	15.00	0	40.00
41.00 ENDOSCOPY INCOME	B	-4,425	OPERATING ROOM	50.00	0	41.00
42.00 OPERATION PLANT	B	-38,173	MAINTENANCE & REPAIRS	6.00	0	42.00
43.00 HOUSEKEEPING OTHER REVENUE	B	-99,760	HOUSEKEEPING	9.00	0	43.00
44.00 RELATED PARTY SALARIES	B	-40,088	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 RELATED PARTY BENEFITS	B	-8,297	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
45.01 2012 & 2014 INTEREST EXPENSE	A	-467,656	CAP REL COSTS-BLDG & FIXT	1.00	11	45.01
45.02 2012 & 2014 INTEREST INCOME	B	-35	CAP REL COSTS-BLDG & FIXT	1.00	11	45.02
45.03 PATIENT TELEPHONE CRC OFFSET	A	-8,442	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.03
45.04 MEALS ON WHEELS	B	-12,110	CAFETERIA	11.00	0	45.04
45.05 POM RELATED RENTAL	A	-3,424	OPERATION OF PLANT	7.00	0	45.05
45.06 WOUND CARE RENTAL	A	-55,943	WOUND CARE	76.01	0	45.06
45.07 HBOT RENTAL	A	-16,206	HYPERBARIC OXYGEN THERAPY	76.98	0	45.07
45.08 ED RELATED RENTAL	A	-10,484	EMERGENCY	91.00	0	45.08
45.09 IDPA PROVIDER TAX	A	-5,649,528	ADMINISTRATIVE & GENERAL	5.00	0	45.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,780,413				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: 140176

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

Worksheet A-8-1

Date/Time Prepared: 11/22/2016 12:53 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CENTEGRA ALLOCATION	16,305,682	23,994,366 1.00
2.00	13.00	NURSING ADMINISTRATION	CENTEGRA ALLOCATION	382,405	0 2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	CENTEGRA ALLOCATION	1,508,963	0 3.00
4.00	91.00	EMERGENCY	CENTEGRA ALLOCATION	201,325	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	CENTEGRA INSURANCE SERVICES	705,573	819,230 4.01
5.00	0			19,103,948	24,813,596 5.00

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

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

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

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

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

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

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

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

Provider CCN: 140176

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

Worksheet A-8-1

Date/Time Prepared:
11/22/2016 12:53 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-7,688,684	0		1.00
2.00	382,405	0		2.00
3.00	1,508,963	0		3.00
4.00	201,325	0		4.00
4.01	-113,657	0		4.01
5.00	-5,709,648			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140176

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

Worksheet A-8-2

Date/Time Prepared:
11/22/2016 12:53 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	90.03	OP BEHAVIORAL HEALTH	11,620	11,620	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	86,713	64,213	22,500	181,300	79	2.00
3.00	50.00	OPERATING ROOM	37,500	0	37,500	246,400	122	3.00
4.00	53.00	ANESTHESIOLOGY	65,000	0	65,000	239,400	2,333	4.00
5.00	91.00	EMERGENCY	414,000	393,988	20,012	211,500	28	5.00
6.00	54.00	DR. AA	72,000	0	72,000	271,900	412	6.00
7.00	54.00	DR. AB	4,800	0	4,800	271,900	218	7.00
8.00	76.97	DR. AC	2,450	0	2,450	211,500	20	8.00
9.00	76.97	DR. AD	1,050	0	1,050	211,500	10	9.00
10.00	76.97	CARDIAC REHABILITATION	-700	-700	0	0	0	10.00
11.00	65.00	RESPIRATORY THERAPY	57,000	57,000	0	0	0	11.00
12.00	76.01	WOUND CARE	11,700	-1,300	13,000	211,500	46	12.00
13.00	70.01	SLEEP LAB/NEUROLOGY	12,483	4,983	7,500	211,500	21	13.00
14.00	66.00	PHYSICAL THERAPY	9,000	0	9,000	211,500	15	14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	15,400	15,400	0	0	0	15.00
16.00	5.00	DR. AE	6,012	0	6,012	211,500	48	16.00
17.00	5.00	DR. AF	7,200	0	7,200	211,500	118	17.00
18.00	5.00	DR. AG	2,625	0	2,625	211,500	7	18.00
200.00			815,853	545,204	270,649		3,477	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	90.03	OP BEHAVIORAL HEALTH	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	6,886	344	0	0	0	2.00
3.00	50.00	OPERATING ROOM	14,452	723	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	268,519	13,426	0	0	0	4.00
5.00	91.00	EMERGENCY	2,847	142	0	0	0	5.00
6.00	54.00	DR. AA	53,857	2,693	0	0	0	6.00
7.00	54.00	DR. AB	28,497	1,425	0	0	0	7.00
8.00	76.97	DR. AC	2,034	102	0	0	0	8.00
9.00	76.97	DR. AD	1,017	51	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
11.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	11.00
12.00	76.01	WOUND CARE	4,677	234	0	0	0	12.00
13.00	70.01	SLEEP LAB/NEUROLOGY	2,135	107	0	0	0	13.00
14.00	66.00	PHYSICAL THERAPY	1,525	76	0	0	0	14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	15.00
16.00	5.00	DR. AE	4,881	244	0	0	0	16.00
17.00	5.00	DR. AF	11,999	600	0	0	0	17.00
18.00	5.00	DR. AG	712	36	0	0	0	18.00
200.00			404,038	20,203	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	90.03	OP BEHAVIORAL HEALTH	0	0	0	11,620		1.00
2.00	40.00	SUBPROVIDER - IPF	0	6,886	15,614	79,827		2.00
3.00	50.00	OPERATING ROOM	0	14,452	23,048	23,048		3.00
4.00	53.00	ANESTHESIOLOGY	0	268,519	0	0		4.00
5.00	91.00	EMERGENCY	0	2,847	17,165	411,153		5.00
6.00	54.00	DR. AA	0	53,857	18,143	18,143		6.00
7.00	54.00	DR. AB	0	28,497	0	0		7.00
8.00	76.97	DR. AC	0	2,034	416	416		8.00
9.00	76.97	DR. AD	0	1,017	33	33		9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	-700		10.00
11.00	65.00	RESPIRATORY THERAPY	0	0	0	57,000		11.00
12.00	76.01	WOUND CARE	0	4,677	8,323	7,023		12.00
13.00	70.01	SLEEP LAB/NEUROLOGY	0	2,135	5,365	10,348		13.00
14.00	66.00	PHYSICAL THERAPY	0	1,525	7,475	7,475		14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	15,400		15.00
16.00	5.00	DR. AE	0	4,881	1,131	1,131		16.00
17.00	5.00	DR. AF	0	11,999	0	0		17.00
18.00	5.00	DR. AG	0	712	1,913	1,913		18.00
200.00			0	404,038	98,626	643,830		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140176

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

Worksheet B
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,776,889	2,776,889			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,312,922		4,312,922		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,523,945	0	0	10,523,945	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	19,223,417	1,040,034	1,615,322	555,927	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,527,682	359,845	558,894	177,565	6.00
7.00 00700	OPERATION OF PLANT	2,214,601	10,940	16,992	291,910	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	435,722	6,187	9,609	14,294	8.00
9.00 00900	HOUSEKEEPING	1,590,678	27,603	42,872	274,311	9.00
10.00 01000	DIETARY	1,128,098	96,697	150,185	136,526	10.00
11.00 01100	CAFETERIA	482,683	0	0	149,135	11.00
13.00 01300	NURSING ADMINISTRATION	1,723,556	3,679	5,715	351,850	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,310,839	54,458	84,581	91,195	14.00
15.00 01500	PHARMACY	2,041,824	26,325	40,887	773,334	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,509,455	39,667	61,609	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,579,663	200,241	311,004	1,848,903	30.00
31.00 03100	INTENSIVE CARE UNIT	2,197,409	60,351	93,735	514,051	31.00
40.00 04000	SUBPROVIDER - IPF	3,575,444	130,056	201,996	944,194	40.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,296,474	238,150	369,882	1,226,408	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	249,401	0	0	4,922	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,643,609	97,463	151,374	514,992	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	566,883	10,224	15,880	74,650	56.00
57.00 05700	CT SCAN	907,243	11,315	17,574	155,021	57.00
58.00 05800	MRI	385,981	15,027	23,339	64,455	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	2,414,501	49,728	77,236	53	60.00
65.00 06500	RESPIRATORY THERAPY	919,409	0	0	205,476	65.00
66.00 06600	PHYSICAL THERAPY	376,608	7,538	11,707	100,517	66.00
67.00 06700	OCCUPATIONAL THERAPY	93,693	0	0	25,113	67.00
68.00 06800	SPEECH PATHOLOGY	66,590	0	0	17,522	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	967,784	25,129	39,029	207,040	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,813,564	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	2,026,989	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,062,817	0	0	0	73.00
76.00 03140	CARDIOLOGY	287,692	63,461	98,564	70,901	76.00
76.01 03950	WOUND CARE	1,386,326	0	0	176,486	76.01
76.97 07697	CARDIAC REHABILITATION	322,008	26,545	41,229	82,818	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	267,472	0	0	30,993	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOMENS CENTER	0	0	0	0	90.01
90.02 09002	PSYCH SERVICES	0	0	0	0	90.02
90.03 09003	OP BEHAVIORAL HEALTH	809,619	58,276	90,511	207,096	90.03
90.04 09004	DIABETES CENTER	0	0	0	0	90.04
91.00 09100	EMERGENCY	3,938,371	85,716	133,130	823,855	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	100,957,861	2,744,655	4,262,856	10,111,513	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,679	5,715	0	190.00
190.02 19002	CRISIS PROGRAM	1,573,056	10,761	16,714	412,432	190.02
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	17,794	27,637	0	192.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	102,530,917	2,776,889	4,312,922	10,523,945	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140176

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

Worksheet B
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	22,434,700					5.00
6.00	00600	734,971	3,358,957				6.00
7.00	00700	709,890	26,687	3,271,020			7.00
8.00	00800	130,473	15,091	14,814	626,190		8.00
9.00	00900	542,118	67,333	66,096	0	2,611,011	9.00
10.00	01000	423,368	235,875	231,539	0	189,508	10.00
11.00	01100	176,970	0	0	0	0	11.00
13.00	01300	583,946	8,975	8,810	0	7,211	13.00
14.00	01400	431,650	132,840	130,398	0	106,727	14.00
15.00	01500	807,343	64,216	63,035	0	51,593	15.00
16.00	01600	451,161	96,760	94,982	0	77,740	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,784,098	488,449	479,471	139,357	392,433	30.00
31.00	03100	802,631	147,216	144,510	27,505	118,277	31.00
40.00	04000	1,358,944	317,247	311,415	62,868	254,884	40.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,557,542	580,921	570,244	151,539	466,724	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	71,235	0	0	0	0	53.00
54.00	05400	954,413	237,741	233,371	51,735	191,008	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	187,003	24,940	24,481	0	20,037	56.00
57.00	05700	305,629	27,600	27,093	0	22,175	57.00
58.00	05800	136,912	36,655	35,981	0	29,450	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	711,872	121,303	119,073	0	97,458	60.00
65.00	06500	315,077	0	0	0	0	65.00
66.00	06600	139,032	18,387	18,049	0	14,773	66.00
67.00	06700	33,277	0	0	0	0	67.00
68.00	06800	23,560	0	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	347,035	61,297	60,170	0	49,248	70.01
71.00	07100	1,348,265	0	0	0	0	71.00
72.00	07200	567,754	0	0	0	0	72.00
73.00	07300	1,698,177	0	0	0	0	73.00
76.00	03140	145,824	154,801	151,956	38,637	124,371	76.00
76.01	03950	437,739	0	0	0	0	76.01
76.97	07697	132,374	64,752	63,562	51,079	52,023	76.97
76.98	07698	83,599	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	326,454	142,152	139,539	0	114,209	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	1,395,183	209,088	205,245	103,470	167,987	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		21,855,519	3,280,326	3,193,834	626,190	2,547,836	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,631	8,975	8,810	0	7,211	190.00
190.02	19002	563,825	26,250	25,768	0	21,090	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	12,725	43,406	42,608	0	34,874	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		22,434,700	3,358,957	3,271,020	626,190	2,611,011	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140176

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

Worksheet B
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	2,591,796					10.00	
11.00	01100	0	808,788				11.00	
13.00	01300	0	25,742	2,719,484			13.00	
14.00	01400	0	15,507	0	2,358,195		14.00	
15.00	01500	0	55,451	0	0	3,924,008	15.00	
16.00	01600	0	0	0	0	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	1,382,047	187,309	855,997	0	0	30.00	
31.00	03100	251,181	44,346	202,657	0	0	31.00	
40.00	04000	958,568	85,793	392,069	0	0	40.00	
43.00	04300	0	0	0	0	0	43.00	
44.00	04400	0	0	0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	100,974	461,443	0	0	50.00	
52.00	05200	0	0	0	0	0	52.00	
53.00	05300	0	870	3,974	0	0	53.00	
54.00	05400	0	43,947	0	0	0	54.00	
55.00	05500	0	0	0	0	0	55.00	
56.00	05600	0	5,072	0	0	0	56.00	
57.00	05700	0	12,826	0	0	0	57.00	
58.00	05800	0	4,493	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	0	0	0	0	60.00	
65.00	06500	0	20,053	91,643	0	0	65.00	
66.00	06600	0	7,482	0	0	0	66.00	
67.00	06700	0	1,902	0	0	0	67.00	
68.00	06800	0	1,250	0	0	0	68.00	
70.00	07000	0	0	0	0	0	70.00	
70.01	07001	0	21,086	96,362	0	0	70.01	
71.00	07100	0	0	0	1,659,417	0	71.00	
72.00	07200	0	0	0	698,778	0	72.00	
73.00	07300	0	0	0	0	3,924,008	73.00	
76.00	03140	0	6,612	30,216	0	0	76.00	
76.01	03950	0	18,079	82,619	0	0	76.01	
76.97	07697	0	6,721	30,713	0	0	76.97	
76.98	07698	0	3,243	14,818	0	0	76.98	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
90.01	09001	0	0	0	0	0	90.01	
90.02	09002	0	0	0	0	0	90.02	
90.03	09003	0	21,756	99,425	0	0	90.03	
90.04	09004	0	0	0	0	0	90.04	
91.00	09100	0	78,239	357,548	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		2,591,796	768,753	2,719,484	2,358,195	3,924,008	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
190.02	19002	0	0	0	0	0	190.02	
191.00	19100	0	40,035	0	0	0	191.00	
192.00	19200	0	0	0	0	0	192.00	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		2,591,796	808,788	2,719,484	2,358,195	3,924,008	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140176

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

Worksheet B
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,331,374				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	174,891	0	16,823,863	0	16,823,863
31.00	03100	INTENSIVE CARE UNIT	43,993	0	4,647,862	0	4,647,862
40.00	04000	SUBPROVIDER - IPF	84,679	0	8,678,157	0	8,678,157
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	378,336	0	14,398,637	0	14,398,637
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	39,224	0	369,626	0	369,626
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,087	0	5,286,740	0	5,286,740
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	33,445	0	962,615	0	962,615
57.00	05700	CT SCAN	245,156	0	1,731,632	0	1,731,632
58.00	05800	MRI	82,482	0	814,775	0	814,775
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	207,166	0	3,798,390	0	3,798,390
65.00	06500	RESPIRATORY THERAPY	34,533	0	1,586,191	0	1,586,191
66.00	06600	PHYSICAL THERAPY	6,510	0	700,603	0	700,603
67.00	06700	OCCUPATIONAL THERAPY	3,152	0	157,137	0	157,137
68.00	06800	SPEECH PATHOLOGY	2,287	0	111,209	2	111,209
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	63,216	0	1,937,396	0	1,937,396
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	80,929	0	7,902,175	0	7,902,175
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,725	0	3,359,246	0	3,359,246
73.00	07300	DRUGS CHARGED TO PATIENTS	207,591	0	11,892,593	0	11,892,593
76.00	03140	CARDIOLOGY	15,250	0	1,188,285	0	1,188,285
76.01	03950	WOUND CARE	57,678	0	2,158,927	0	2,158,927
76.97	07697	CARDIAC REHABILITATION	8,225	0	882,049	0	882,049
76.98	07698	HYPERBARIC OXYGEN THERAPY	16,176	0	416,301	0	416,301
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	49,696	0	2,058,733	0	2,058,733
90.04	09004	DIABETES CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	263,947	0	7,761,779	0	7,761,779
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,331,374	0	99,624,921	0	99,624,921
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	37,021	0	37,021
190.02	19002	CRISIS PROGRAM	0	0	2,649,896	0	2,649,896
191.00	19100	RESEARCH	0	0	40,035	0	40,035
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	179,044	0	179,044
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,331,374	0	102,530,917	0	102,530,917

COST ALLOCATION STATISTICS

Provider CCN: 140176

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

Worksheet Non-CMS W
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	2	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	FTE	11.00
13.00	NURSING ADMINISTRATION	13	NURSING HOURS/FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS	14.00
15.00	PHARMACY	15	COSTED REQUIS	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	16	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140176

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

Worksheet B
Part II
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	478,906	1,040,034	1,615,322	5.00
6.00 00600	MAINTENANCE & REPAIRS	19,200	359,845	558,894	6.00
7.00 00700	OPERATION OF PLANT	6,327	10,940	16,992	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,187	9,609	8.00
9.00 00900	HOUSEKEEPING	0	27,603	42,872	9.00
10.00 01000	DIETARY	1,556	96,697	150,185	10.00
11.00 01100	CAFETERIA	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,031	3,679	5,715	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	477,408	54,458	84,581	14.00
15.00 01500	PHARMACY	396,825	26,325	40,887	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	39,667	61,609	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	2,495	200,241	311,004	30.00
31.00 03100	INTENSIVE CARE UNIT	5,852	60,351	93,735	31.00
40.00 04000	SUBPROVIDER - IPF	0	130,056	201,996	40.00
43.00 04300	NURSERY	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	177,511	238,150	369,882	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	6,574	0	6,574	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,030	97,463	151,374	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	10,224	15,880	56.00
57.00 05700	CT SCAN	0	11,315	17,574	57.00
58.00 05800	MRI	0	15,027	23,339	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	1,107	49,728	77,236	60.00
65.00 06500	RESPIRATORY THERAPY	7,989	0	7,989	65.00
66.00 06600	PHYSICAL THERAPY	0	7,538	11,707	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	415	0	415	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	103,385	25,129	39,029	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03140	CARDIOLOGY	0	63,461	98,564	76.00
76.01 03950	WOUND CARE	112,332	0	112,332	76.01
76.97 07697	CARDIAC REHABILITATION	0	26,545	41,229	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	31,345	0	31,345	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	0	0	0	90.00
90.01 09001	WOMENS CENTER	0	0	0	90.01
90.02 09002	PSYCH SERVICES	0	0	0	90.02
90.03 09003	OP BEHAVIORAL HEALTH	0	58,276	90,511	90.03
90.04 09004	DIABETES CENTER	0	0	0	90.04
91.00 09100	EMERGENCY	18,558	85,716	133,130	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,849,846	2,744,655	4,262,856	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,679	5,715	190.00
190.02 19002	CRISIS PROGRAM	0	10,761	16,714	190.02
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	17,794	27,637	192.00
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,849,846	2,776,889	4,312,922	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140176

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

Worksheet B
Part II
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	3,134,262					5.00
6.00	00600	102,679	1,040,618				6.00
7.00	00700	99,175	8,268	141,702			7.00
8.00	00800	18,228	4,675		642	39,341	8.00
9.00	00900	75,737	20,860	2,863	0	169,935	9.00
10.00	01000	59,147	73,075	10,030	0	12,334	10.00
11.00	01100	24,724	0	0	0	0	11.00
13.00	01300	81,580	2,781	382	0	469	13.00
14.00	01400	60,304	41,154	5,649	0	6,946	14.00
15.00	01500	112,790	19,894	2,731	0	3,358	15.00
16.00	01600	63,030	29,977	4,115	0	5,060	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	388,973	151,323	20,771	8,755	25,541	30.00
31.00	03100	112,132	45,608	6,260	1,728	7,698	31.00
40.00	04000	189,851	98,284	13,491	3,950	16,589	40.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	357,302	179,974	24,700	9,521	30,376	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	9,952	0	0	0	0	53.00
54.00	05400	133,336	73,653	10,110	3,250	12,432	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	26,125	7,726	1,061	0	1,304	56.00
57.00	05700	42,698	8,551	1,174	0	1,443	57.00
58.00	05800	19,127	11,356	1,559	0	1,917	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	99,452	37,580	5,158	0	6,343	60.00
65.00	06500	44,018	0	0	0	0	65.00
66.00	06600	19,423	5,696	782	0	961	66.00
67.00	06700	4,649	0	0	0	0	67.00
68.00	06800	3,291	0	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	48,483	18,990	2,607	0	3,205	70.01
71.00	07100	188,360	0	0	0	0	71.00
72.00	07200	79,318	0	0	0	0	72.00
73.00	07300	237,244	0	0	0	0	73.00
76.00	03140	20,372	47,958	6,583	2,427	8,095	76.00
76.01	03950	61,154	0	0	0	0	76.01
76.97	07697	18,493	20,060	2,754	3,209	3,386	76.97
76.98	07698	11,679	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	45,607	44,039	6,045	0	7,433	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	194,914	64,776	8,891	6,501	10,933	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,053,347	1,016,258	138,358	39,341	165,823	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	368	2,781	382	0	469	190.00
190.02	19002	78,769	8,132	1,116	0	1,373	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	1,778	13,447	1,846	0	2,270	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,134,262	1,040,618	141,702	39,341	169,935	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140176		Period: From 07/01/2015 To 06/30/2016		Worksheet B Part II Date/Time Prepared: 11/22/2016 12:53 pm		
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	403,024					10.00	
11.00	01100	0	24,724				11.00	
13.00	01300	0	787	96,424			13.00	
14.00	01400	0	474	0	730,974		14.00	
15.00	01500	0	1,695	0	0	604,505	15.00	
16.00	01600	0	0	0	0	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	214,908	5,725	30,353	0	0	30.00	
31.00	03100	39,059	1,356	7,186	0	0	31.00	
40.00	04000	149,057	2,623	13,901	0	0	40.00	
43.00	04300	0	0	0	0	0	43.00	
44.00	04400	0	0	0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	3,087	16,361	0	0	50.00	
52.00	05200	0	0	0	0	0	52.00	
53.00	05300	0	27	141	0	0	53.00	
54.00	05400	0	1,343	0	0	0	54.00	
55.00	05500	0	0	0	0	0	55.00	
56.00	05600	0	155	0	0	0	56.00	
57.00	05700	0	392	0	0	0	57.00	
58.00	05800	0	137	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	0	0	0	0	60.00	
65.00	06500	0	613	3,249	0	0	65.00	
66.00	06600	0	229	0	0	0	66.00	
67.00	06700	0	58	0	0	0	67.00	
68.00	06800	0	38	0	0	0	68.00	
70.00	07000	0	0	0	0	0	70.00	
70.01	07001	0	645	3,417	0	0	70.01	
71.00	07100	0	0	0	514,372	0	71.00	
72.00	07200	0	0	0	216,602	0	72.00	
73.00	07300	0	0	0	0	604,505	73.00	
76.00	03140	0	202	1,071	0	0	76.00	
76.01	03950	0	553	2,929	0	0	76.01	
76.97	07697	0	205	1,089	0	0	76.97	
76.98	07698	0	99	525	0	0	76.98	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	0	0	0	0	0	90.00	
90.01	09001	0	0	0	0	0	90.01	
90.02	09002	0	0	0	0	0	90.02	
90.03	09003	0	665	3,525	0	0	90.03	
90.04	09004	0	0	0	0	0	90.04	
91.00	09100	0	2,392	12,677	0	0	91.00	
92.00	09200	0	0	0	0	0	92.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		403,024	23,500	96,424	730,974	604,505	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
190.02	19002	0	0	0	0	0	190.02	
191.00	19100	0	1,224	0	0	0	191.00	
192.00	19200	0	0	0	0	0	192.00	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		403,024	24,724	96,424	730,974	604,505	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140176

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

Worksheet B
Part II
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	203,458				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,250	0	1,375,339	0	1,375,339
31.00	03100	INTENSIVE CARE UNIT	3,836	0	384,801	0	384,801
40.00	04000	SUBPROVIDER - IPF	7,384	0	827,182	0	827,182
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,157	0	1,440,021	0	1,440,021
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,420	0	20,114	0	20,114
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,570	0	498,561	0	498,561
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	2,916	0	65,391	0	65,391
57.00	05700	CT SCAN	21,377	0	104,524	0	104,524
58.00	05800	MRI	7,192	0	79,654	0	79,654
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	18,065	0	294,669	0	294,669
65.00	06500	RESPIRATORY THERAPY	3,011	0	58,880	0	58,880
66.00	06600	PHYSICAL THERAPY	568	0	46,904	0	46,904
67.00	06700	OCCUPATIONAL THERAPY	275	0	4,982	0	4,982
68.00	06800	SPEECH PATHOLOGY	199	0	3,943	0	3,943
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	5,512	0	250,402	0	250,402
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,057	0	709,789	0	709,789
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,731	0	301,651	0	301,651
73.00	07300	DRUGS CHARGED TO PATIENTS	18,102	0	859,851	0	859,851
76.00	03140	CARDIOLOGY	1,330	0	250,063	0	250,063
76.01	03950	WOUND CARE	5,029	0	181,997	0	181,997
76.97	07697	CARDIAC REHABILITATION	717	0	117,687	0	117,687
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,411	0	45,059	0	45,059
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	4,333	0	260,434	0	260,434
90.04	09004	DIABETES CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	23,016	0	561,504	0	561,504
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	203,458	0	8,743,402	0	8,743,402
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	13,394	0	13,394
190.02	19002	CRISIS PROGRAM	0	0	116,865	0	116,865
191.00	19100	RESEARCH	0	0	1,224	0	1,224
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	64,772	0	64,772
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	203,458	0	8,939,657	0	8,939,657

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140176

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

Worksheet B-1

Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	341,133				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		341,133			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	38,974,735		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	127,765	127,765	2,058,835	-22,434,700	5.00
6.00 00600	MAINTENANCE & REPAIRS	44,206	44,206	657,598	0	6.00
7.00 00700	OPERATION OF PLANT	1,344	1,344	1,081,069	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	760	760	52,935	0	8.00
9.00 00900	HOUSEKEEPING	3,391	3,391	1,015,893	0	9.00
10.00 01000	DIETARY	11,879	11,879	505,613	0	10.00
11.00 01100	CAFETERIA	0	0	552,310	0	11.00
13.00 01300	NURSING ADMINISTRATION	452	452	1,303,050	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,690	6,690	337,736	0	14.00
15.00 01500	PHARMACY	3,234	3,234	2,863,987	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,873	4,873	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	24,599	24,599	6,847,329	0	30.00
31.00 03100	INTENSIVE CARE UNIT	7,414	7,414	1,903,752	0	31.00
40.00 04000	SUBPROVIDER - IPF	15,977	15,977	3,496,755	0	40.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	29,256	29,256	4,541,914	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	18,229	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,973	11,973	1,907,238	0	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	1,256	1,256	276,461	0	56.00
57.00 05700	CT SCAN	1,390	1,390	574,110	0	57.00
58.00 05800	MRI	1,846	1,846	238,706	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	6,109	6,109	198	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	760,965	0	65.00
66.00 06600	PHYSICAL THERAPY	926	926	372,257	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	93,005	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	64,890	0	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	3,087	3,087	766,758	0	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03140	CARDIOLOGY	7,796	7,796	262,578	0	76.00
76.01 03950	WOUND CARE	0	0	653,605	0	76.01
76.97 07697	CARDIAC REHABILITATION	3,261	3,261	306,710	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	114,782	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOMENS CENTER	0	0	0	0	90.01
90.02 09002	PSYCH SERVICES	0	0	0	0	90.02
90.03 09003	OP BEHAVIORAL HEALTH	7,159	7,159	766,966	0	90.03
90.04 09004	DIABETES CENTER	0	0	0	0	90.04
91.00 09100	EMERGENCY	10,530	10,530	3,051,087	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	337,173	337,173	37,447,321	-22,434,700	78,028,429
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	452	452	0	0	190.00
190.02 19002	CRISIS PROGRAM	1,322	1,322	1,527,414	0	190.02
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,186	2,186	0	0	192.00
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)	2,776,889	4,312,922	10,523,945		22,434,700
203.00	Unit cost multiplier (Wkst. B, Part I)	8.140195	12.642934	0.270020		0.280097
204.00	Cost to be allocated (per Wkst. B, Part II)			0		3,134,262

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140176

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

Worksheet B-1
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
205.00 Unit cost multiplier (Wkst. B, Part II)			4.00 0.000000	5A	5.00 0.039131	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140176

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

Worksheet B-1

Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	169,162					6.00
7.00	00700	1,344	167,818				7.00
8.00	00800	760	760	617,468			8.00
9.00	00900	3,391	3,391	0	163,667		9.00
10.00	01000	11,879	11,879	0	11,879	168,686	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	452	452	0	452	0	13.00
14.00	01400	6,690	6,690	0	6,690	0	14.00
15.00	01500	3,234	3,234	0	3,234	0	15.00
16.00	01600	4,873	4,873	0	4,873	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	24,599	24,599	137,416	24,599	89,950	30.00
31.00	03100	7,414	7,414	27,122	7,414	16,348	31.00
40.00	04000	15,977	15,977	61,992	15,977	62,388	40.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	29,256	29,256	149,428	29,256	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	11,973	11,973	51,014	11,973	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	1,256	1,256	0	1,256	0	56.00
57.00	05700	1,390	1,390	0	1,390	0	57.00
58.00	05800	1,846	1,846	0	1,846	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	6,109	6,109	0	6,109	0	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	926	926	0	926	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	3,087	3,087	0	3,087	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03140	7,796	7,796	38,099	7,796	0	76.00
76.01	03950	0	0	0	0	0	76.01
76.97	07697	3,261	3,261	50,368	3,261	0	76.97
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	7,159	7,159	0	7,159	0	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	10,530	10,530	102,029	10,530	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		165,202	163,858	617,468	159,707	168,686	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	452	452	0	452	0	190.00
190.02	19002	1,322	1,322	0	1,322	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	2,186	2,186	0	2,186	0	192.00
200.00							200.00
201.00							201.00
202.00		3,358,957	3,271,020	626,190	2,611,011	2,591,796	202.00
203.00		19.856451	19.491473	1.014125	15.953192	15.364618	203.00
204.00		1,040,618	141,702	39,341	169,935	403,024	204.00
205.00		6.151606	0.844379	0.063713	1.038297	2.389196	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140176

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

Worksheet B-1

Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING HOURS/FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	44,647					11.00
13.00	01300	1,421	32,850				13.00
14.00	01400	856	0	6,840,553			14.00
15.00	01500	3,061	0	0	6,062,817		15.00
16.00	01600	0	0	0	0	351,093,192	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,340	10,340	0	0	26,339,051	30.00
31.00	03100	2,448	2,448	0	0	6,625,491	31.00
40.00	04000	4,736	4,736	0	0	12,752,863	40.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,574	5,574	0	0	56,960,824	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	48	48	0	0	5,907,254	53.00
54.00	05400	2,426	0	0	0	25,163,637	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	280	0	0	0	5,036,923	56.00
57.00	05700	708	0	0	0	36,921,076	57.00
58.00	05800	248	0	0	0	12,422,012	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	31,199,645	60.00
65.00	06500	1,107	1,107	0	0	5,200,727	65.00
66.00	06600	413	0	0	0	980,455	66.00
67.00	06700	105	0	0	0	474,725	67.00
68.00	06800	69	0	0	0	344,394	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	1,164	1,164	0	0	9,520,518	70.01
71.00	07100	0	0	4,813,564	0	12,188,139	71.00
72.00	07200	0	0	2,026,989	0	9,898,399	72.00
73.00	07300	0	0	0	6,062,817	31,263,735	73.00
76.00	03140	365	365	0	0	2,296,743	76.00
76.01	03950	998	998	0	0	8,686,440	76.01
76.97	07697	371	371	0	0	1,238,699	76.97
76.98	07698	179	179	0	0	2,436,120	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	1,201	1,201	0	0	7,484,291	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	4,319	4,319	0	0	39,751,031	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		42,437	32,850	6,840,553	6,062,817	351,093,192	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.02	19002	0	0	0	0	0	190.02
191.00	19100	2,210	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		808,788	2,719,484	2,358,195	3,924,008	2,331,374	202.00
203.00		18.115170	82.784901	0.344737	0.647225	0.006640	203.00
204.00		24,724	96,424	730,974	604,505	203,458	204.00
205.00		0.553766	2.935282	0.106859	0.099707	0.000579	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140176

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

Worksheet B-1
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03140	CARDIOLOGY	76.00
76.01	03950	WOUND CARE	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOMENS CENTER	90.01
90.02	09002	PSYCH SERVICES	90.02
90.03	09003	OP BEHAVIORAL HEALTH	90.03
90.04	09004	DIABETES CENTER	90.04
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.02	19002	CRISIS PROGRAM	190.02
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140176		Period: From 07/01/2015 To 06/30/2016		Worksheet C Part I Date/Time Prepared: 11/22/2016 12:53 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		16,823,863	0	16,823,863	30.00	
31.00	03100 INTENSIVE CARE UNIT		4,647,862	0	4,647,862	31.00	
40.00	04000 SUBPROVIDER - IPF		8,678,157	15,614	8,693,771	40.00	
43.00	04300 NURSERY		0	0	0	43.00	
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		14,398,637	23,048	14,421,685	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY		369,626	0	369,626	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,286,740	18,143	5,304,883	54.00	
55.00	05500 RADIOLOGY - THERAPEUTIC		0	0	0	55.00	
56.00	05600 RADIOISOTOPE		962,615	0	962,615	56.00	
57.00	05700 CT SCAN		1,731,632	0	1,731,632	57.00	
58.00	05800 MRI		814,775	0	814,775	58.00	
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	06000 LABORATORY		3,798,390	0	3,798,390	60.00	
65.00	06500 RESPIRATORY THERAPY	0	1,586,191	0	1,586,191	65.00	
66.00	06600 PHYSICAL THERAPY	0	700,603	7,475	708,078	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	157,137	0	157,137	67.00	
68.00	06800 SPEECH PATHOLOGY	0	111,209	0	111,209	68.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00	
70.01	07001 SLEEP LAB/NEUROLOGY		1,937,396	5,365	1,942,761	70.01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		7,902,175	0	7,902,175	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,359,246	0	3,359,246	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		11,892,593	0	11,892,593	73.00	
76.00	03140 RADIOLOGY		1,188,285	0	1,188,285	76.00	
76.01	03950 WOUND CARE		2,158,927	8,323	2,167,250	76.01	
76.97	07697 CARDIAC REHABILITATION		882,049	449	882,498	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY		416,301	0	416,301	76.98	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		0	0	0	90.00	
90.01	09001 WOMENS CENTER		0	0	0	90.01	
90.02	09002 PSYCH SERVICES		0	0	0	90.02	
90.03	09003 OP BEHAVIORAL HEALTH		2,058,733	0	2,058,733	90.03	
90.04	09004 DIABETES CENTER		0	0	0	90.04	
91.00	09100 EMERGENCY		7,761,779	17,165	7,778,944	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		2,601,595	0	2,601,595	92.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE		0	0	0	113.00	
200.00	Subtotal (see instructions)		102,226,516	95,582	102,322,098	200.00	
201.00	Less Observation Beds		2,601,595	0	2,601,595	201.00	
202.00	Total (see instructions)		99,624,921	95,582	99,720,503	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140176

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

Worksheet C
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

		Title XVIIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,867,908		22,867,908		30.00
31.00	03100	INTENSIVE CARE UNIT	6,625,491		6,625,491		31.00
40.00	04000	SUBPROVIDER - IPF	12,752,863		12,752,863		40.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,728,526	44,232,298	56,960,824	0.252781	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,679,403	4,227,851	5,907,254	0.062572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,333,313	19,830,324	25,163,637	0.210094	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	538,243	4,498,680	5,036,923	0.191112	56.00
57.00	05700	CT SCAN	8,368,043	28,553,033	36,921,076	0.046901	57.00
58.00	05800	MRI	1,434,395	10,987,617	12,422,012	0.065591	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	15,157,104	16,042,541	31,199,645	0.121745	60.00
65.00	06500	RESPIRATORY THERAPY	4,373,542	827,185	5,200,727	0.304994	65.00
66.00	06600	PHYSICAL THERAPY	896,972	83,483	980,455	0.714569	66.00
67.00	06700	OCCUPATIONAL THERAPY	449,525	25,200	474,725	0.331006	67.00
68.00	06800	SPEECH PATHOLOGY	333,305	11,089	344,394	0.322912	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	78,400	9,442,118	9,520,518	0.203497	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,762,146	5,425,993	12,188,139	0.648350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,908,393	2,990,006	9,898,399	0.339373	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,686,281	16,577,454	31,263,735	0.380396	73.00
76.00	03140	CARDIOLOGY	150,003	2,146,740	2,296,743	0.517378	76.00
76.01	03950	WOUND CARE	17,347	8,669,093	8,686,440	0.248540	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,238,699	1,238,699	0.712077	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,202	2,433,918	2,436,120	0.170887	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOMENS CENTER	0	0	0	0.000000	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	3,383	7,480,908	7,484,291	0.275074	90.03
90.04	09004	DIABETES CENTER	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	9,383,204	30,367,827	39,751,031	0.195260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,471,143	3,471,143	0.749492	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	131,529,992	219,563,200	351,093,192		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	131,529,992	219,563,200	351,093,192		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.253186		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.062572		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.210815		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000		55.00
56.00	05600 RADIOISOTOPE	0.191112		56.00
57.00	05700 CT SCAN	0.046901		57.00
58.00	05800 MRI	0.065591		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.121745		60.00
65.00	06500 RESPIRATORY THERAPY	0.304994		65.00
66.00	06600 PHYSICAL THERAPY	0.722193		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.331006		67.00
68.00	06800 SPEECH PATHOLOGY	0.322912		68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.204060		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.648350		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339373		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.380396		73.00
76.00	03140 RADIOLOGY	0.517378		76.00
76.01	03950 WOUND CARE	0.249498		76.01
76.97	07697 CARDIAC REHABILITATION	0.712439		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.170887		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOMENS CENTER	0.000000		90.01
90.02	09002 PSYCH SERVICES	0.000000		90.02
90.03	09003 OP BEHAVIORAL HEALTH	0.275074		90.03
90.04	09004 DIABETES CENTER	0.000000		90.04
91.00	09100 EMERGENCY	0.195692		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.749492		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/22/2016 12:53 pm
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Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	Hospital		
				RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		16,823,863	0	16,823,863	30.00
31.00	03100 INTENSIVE CARE UNIT		4,647,862	0	4,647,862	31.00
40.00	04000 SUBPROVIDER - IPF		8,678,157	15,614	8,693,771	40.00
43.00	04300 NURSERY		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		14,398,637	23,048	14,421,685	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY		369,626	0	369,626	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,286,740	18,143	5,304,883	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		0	0	0	55.00
56.00	05600 RADIOISOTOPE		962,615	0	962,615	56.00
57.00	05700 CT SCAN		1,731,632	0	1,731,632	57.00
58.00	05800 MRI		814,775	0	814,775	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		3,798,390	0	3,798,390	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,586,191	0	1,586,191	65.00
66.00	06600 PHYSICAL THERAPY	0	700,603	7,475	708,078	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	157,137	0	157,137	67.00
68.00	06800 SPEECH PATHOLOGY	0	111,209	0	111,209	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY		1,937,396	5,365	1,942,761	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		7,902,175	0	7,902,175	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		3,359,246	0	3,359,246	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		11,892,593	0	11,892,593	73.00
76.00	03140 RADIOLOGY		1,188,285	0	1,188,285	76.00
76.01	03950 WOUND CARE		2,158,927	8,323	2,167,250	76.01
76.97	07697 CARDIAC REHABILITATION		882,049	449	882,498	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY		416,301	0	416,301	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.01	09001 WOMENS CENTER		0	0	0	90.01
90.02	09002 PSYCH SERVICES		0	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH		2,058,733	0	2,058,733	90.03
90.04	09004 DIABETES CENTER		0	0	0	90.04
91.00	09100 EMERGENCY		7,761,779	17,165	7,778,944	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		2,601,595	0	2,601,595	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
200.00	Subtotal (see instructions)		102,226,516	95,582	102,322,098	200.00
201.00	Less Observation Beds		2,601,595	0	2,601,595	201.00
202.00	Total (see instructions)		99,624,921	95,582	99,720,503	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140176

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

Worksheet C
Part I
Date/Time Prepared:
11/22/2016 12:53 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,867,908		22,867,908		30.00
31.00	03100	INTENSIVE CARE UNIT	6,625,491		6,625,491		31.00
40.00	04000	SUBPROVIDER - IPF	12,752,863		12,752,863		40.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,728,526	44,232,298	56,960,824	0.252781	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,679,403	4,227,851	5,907,254	0.062572	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,333,313	19,830,324	25,163,637	0.210094	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	538,243	4,498,680	5,036,923	0.191112	56.00
57.00	05700	CT SCAN	8,368,043	28,553,033	36,921,076	0.046901	57.00
58.00	05800	MRI	1,434,395	10,987,617	12,422,012	0.065591	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	15,157,104	16,042,541	31,199,645	0.121745	60.00
65.00	06500	RESPIRATORY THERAPY	4,373,542	827,185	5,200,727	0.304994	65.00
66.00	06600	PHYSICAL THERAPY	896,972	83,483	980,455	0.714569	66.00
67.00	06700	OCCUPATIONAL THERAPY	449,525	25,200	474,725	0.331006	67.00
68.00	06800	SPEECH PATHOLOGY	333,305	11,089	344,394	0.322912	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	78,400	9,442,118	9,520,518	0.203497	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,762,146	5,425,993	12,188,139	0.648350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,908,393	2,990,006	9,898,399	0.339373	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,686,281	16,577,454	31,263,735	0.380396	73.00
76.00	03140	CARDIOLOGY	150,003	2,146,740	2,296,743	0.517378	76.00
76.01	03950	WOUND CARE	17,347	8,669,093	8,686,440	0.248540	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,238,699	1,238,699	0.712077	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,202	2,433,918	2,436,120	0.170887	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOMENS CENTER	0	0	0	0.000000	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	3,383	7,480,908	7,484,291	0.275074	90.03
90.04	09004	DIABETES CENTER	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	9,383,204	30,367,827	39,751,031	0.195260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,471,143	3,471,143	0.749492	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	131,529,992	219,563,200	351,093,192		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	131,529,992	219,563,200	351,093,192		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140176

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

Worksheet C
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.000000			70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03140 RADIOLOGY	0.000000			76.00
76.01	03950 WOUND CARE	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 WOMENS CENTER	0.000000			90.01
90.02	09002 PSYCH SERVICES	0.000000			90.02
90.03	09003 OP BEHAVIORAL HEALTH	0.000000			90.03
90.04	09004 DIABETES CENTER	0.000000			90.04
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140176

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

Worksheet D
Part I
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,375,339	0	1,375,339	14,091	97.60	30.00	
31.00	INTENSIVE CARE UNIT	384,801		384,801	2,165	177.74	31.00	
40.00	SUBPROVIDER - IPF	827,182	0	827,182	8,262	100.12	40.00	
43.00	NURSERY	0		0	0	0.00	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
200.00	Total (lines 30-199)	2,587,322		2,587,322	24,518		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	6,596	643,770					30.00
31.00	INTENSIVE CARE UNIT	1,156	205,467					31.00
40.00	SUBPROVIDER - IPF	2,386	238,886					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30-199)	10,138	1,088,123					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140176

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

Worksheet D
Part II
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,440,021	56,960,824	0.025281	5,030,690	127,181	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	20,114	5,907,254	0.003405	594,458	2,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	498,561	25,163,637	0.019813	3,044,858	60,328	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	65,391	5,036,923	0.012982	301,742	3,917	56.00
57.00	05700	CT SCAN	104,524	36,921,076	0.002831	4,262,362	12,067	57.00
58.00	05800	MRI	79,654	12,422,012	0.006412	718,439	4,607	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	294,669	31,199,645	0.009445	7,337,425	69,302	60.00
65.00	06500	RESPIRATORY THERAPY	58,880	5,200,727	0.011321	2,361,356	26,733	65.00
66.00	06600	PHYSICAL THERAPY	46,904	980,455	0.047839	607,776	29,075	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,982	474,725	0.010494	276,366	2,900	67.00
68.00	06800	SPEECH PATHOLOGY	3,943	344,394	0.011449	208,558	2,388	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	250,402	9,520,518	0.026301	49,185	1,294	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	709,789	12,188,139	0.058236	2,004,901	116,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	301,651	9,898,399	0.030475	2,882,795	87,853	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	859,851	31,263,735	0.027503	6,670,080	183,447	73.00
76.00	03140	CARDIOLOGY	250,063	2,296,743	0.108877	84,292	9,177	76.00
76.01	03950	WOUND CARE	181,997	8,686,440	0.020952	15,720	329	76.01
76.97	07697	CARDIAC REHABILITATION	117,687	1,238,699	0.095009	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	45,059	2,436,120	0.018496	2,202	41	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0.000000	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0.000000	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	260,434	7,484,291	0.034797	0	0	90.03
90.04	09004	DIABETES CENTER	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	561,504	39,751,031	0.014126	4,412,376	62,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	212,678	3,471,143	0.061270	0	0	92.00
200.00		Total (lines 50-199)	6,368,758	308,846,930		40,865,581	801,749	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part III Date/Time Prepared: 11/22/2016 12:53 pm
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Cost Center Description		Title XVIII					Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)				
		1.00	2.00	3.00	4.00	5.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School				
		6.00	7.00	8.00	9.00	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	14,091	0.00	6,596	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,165	0.00	1,156	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	8,262	0.00	2,386	0	0	0	0	40.00
43.00	04300	NURSERY	0	0.00	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	24,518		10,138	0	0	0	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost							
		12.00	13.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0	0						31.00
40.00	04000	SUBPROVIDER - IPF	0	0						40.00
43.00	04300	NURSERY	0	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0	0						44.00
200.00		Total (lines 30-199)	0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140176

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	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
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0	0	0	0	0	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	0	0	90.04
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: 140176

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:53 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	56,960,824	0.000000	0.000000	5,030,690	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,907,254	0.000000	0.000000	594,458	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,163,637	0.000000	0.000000	3,044,858	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	5,036,923	0.000000	0.000000	301,742	56.00
57.00	05700	CT SCAN	0	36,921,076	0.000000	0.000000	4,262,362	57.00
58.00	05800	MRI	0	12,422,012	0.000000	0.000000	718,439	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	31,199,645	0.000000	0.000000	7,337,425	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,200,727	0.000000	0.000000	2,361,356	65.00
66.00	06600	PHYSICAL THERAPY	0	980,455	0.000000	0.000000	607,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	474,725	0.000000	0.000000	276,366	67.00
68.00	06800	SPEECH PATHOLOGY	0	344,394	0.000000	0.000000	208,558	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	9,520,518	0.000000	0.000000	49,185	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,188,139	0.000000	0.000000	2,004,901	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,898,399	0.000000	0.000000	2,882,795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,263,735	0.000000	0.000000	6,670,080	73.00
76.00	03140	CARDIOLOGY	0	2,296,743	0.000000	0.000000	84,292	76.00
76.01	03950	WOUND CARE	0	8,686,440	0.000000	0.000000	15,720	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,238,699	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,436,120	0.000000	0.000000	2,202	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOMENS CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0.000000	0.000000	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	7,484,291	0.000000	0.000000	0	90.03
90.04	09004	DIABETES CENTER	0	0	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	39,751,031	0.000000	0.000000	4,412,376	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,471,143	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	308,846,930			40,865,581	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140176

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:53 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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	13,131,378	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	908,497	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,428,056	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	1,855,405	0	0	0	56.00
57.00	05700 CT SCAN	0	7,720,385	0	0	0	57.00
58.00	05800 MRI	0	3,127,273	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	4,077,108	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	297,498	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	20,173	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	4,292	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	360	0	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	2,846,567	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,082,882	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	621,080	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,405,090	0	0	0	73.00
76.00	03140 CARDIOLOGY	0	768,478	0	0	0	76.00
76.01	03950 WOUND CARE	0	5,094,890	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	621,166	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	940,713	0	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100 EMERGENCY	0	6,049,661	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	825,603	0	0	0	92.00
200.00	Total (lines 50-199)	0	62,826,555	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140176

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03140	CARDIOLOGY	0	0		76.00
76.01	03950	WOUND CARE	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOMENS CENTER	0	0		90.01
90.02	09002	PSYCH SERVICES	0	0		90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0		90.03
90.04	09004	DIABETES CENTER	0	0		90.04
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: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.252781	13,131,378	0	0	3,319,363	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.062572	908,497	0	0	56,846	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.210094	5,428,056	0	0	1,140,402	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.191112	1,855,405	0	0	354,590	56.00
57.00	05700 CT SCAN	0.046901	7,720,385	0	0	362,094	57.00
58.00	05800 MRI	0.065591	3,127,273	0	0	205,121	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.121745	4,077,108	0	0	496,368	60.00
65.00	06500 RESPIRATORY THERAPY	0.304994	297,498	82	0	90,735	65.00
66.00	06600 PHYSICAL THERAPY	0.714569	20,173	0	0	14,415	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.331006	4,292	0	0	1,421	67.00
68.00	06800 SPEECH PATHOLOGY	0.322912	360	0	0	116	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.203497	2,846,567	0	0	579,268	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.648350	1,082,882	0	0	702,087	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339373	621,080	21,000	0	210,778	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.380396	7,405,090	0	25,125	2,816,867	73.00
76.00	03140 CARDIOLOGY	0.517378	768,478	0	0	397,594	76.00
76.01	03950 WOUND CARE	0.248540	5,094,890	0	0	1,266,284	76.01
76.97	07697 CARDIAC REHABILITATION	0.712077	621,166	0	0	442,318	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.170887	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 WOMENS CENTER	0.000000	0	0	0	0	90.01
90.02	09002 PSYCH SERVICES	0.000000	0	0	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0.275074	940,713	0	0	258,766	90.03
90.04	09004 DIABETES CENTER	0.000000	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.195260	6,049,661	0	0	1,181,257	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.749492	825,603	0	0	618,783	92.00
200.00	Subtotal (see instructions)		62,826,555	21,082	25,125	14,515,473	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		62,826,555	21,082	25,125	14,515,473	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 12:53 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		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	25	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7,127	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,557	73.00
76.00	03140 CARDIOLOGY	0	0	76.00
76.01	03950 WOUND CARE	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	90.04
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)	7,152	9,557	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	7,152	9,557	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/22/2016 12:53 pm
		Component CCN: 14S176	Title XVIII	Subprovider - IPF

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,440,021	56,960,824	0.025281	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	20,114	5,907,254	0.003405	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	498,561	25,163,637	0.019813	9,869	196	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	65,391	5,036,923	0.012982	0	0	56.00
57.00	05700 CT SCAN	104,524	36,921,076	0.002831	21,918	62	57.00
58.00	05800 MRI	79,654	12,422,012	0.006412	19,924	128	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	294,669	31,199,645	0.009445	446,638	4,218	60.00
65.00	06500 RESPIRATORY THERAPY	58,880	5,200,727	0.011321	18,921	214	65.00
66.00	06600 PHYSICAL THERAPY	46,904	980,455	0.047839	10,078	482	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,982	474,725	0.010494	3,735	39	67.00
68.00	06800 SPEECH PATHOLOGY	3,943	344,394	0.011449	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	250,402	9,520,518	0.026301	1,664	44	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	709,789	12,188,139	0.058236	2,047	119	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	301,651	9,898,399	0.030475	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	859,851	31,263,735	0.027503	453,014	12,459	73.00
76.00	03140 RADIOLOGY	250,063	2,296,743	0.108877	0	0	76.00
76.01	03950 WOUND CARE	181,997	8,686,440	0.020952	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	117,687	1,238,699	0.095009	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	45,059	2,436,120	0.018496	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	0.000000	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	0.000000	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	260,434	7,484,291	0.034797	2,573	90	90.03
90.04	09004 DIABETES CENTER	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	561,504	39,751,031	0.014126	357,838	5,055	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3,471,143	0.000000	0	0	92.00
200.00	Total (lines 50-199)	6,156,080	308,846,930		1,348,219	23,106	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 12:53 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03140 CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950 WOUND CARE	0	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	0	0	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 12:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	56,960,824	0.000000	0.000000	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	5,907,254	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	25,163,637	0.000000	0.000000	9,869	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00 05600 RADIOISOTOPE	0	5,036,923	0.000000	0.000000	0	56.00
57.00 05700 CT SCAN	0	36,921,076	0.000000	0.000000	21,918	57.00
58.00 05800 MRI	0	12,422,012	0.000000	0.000000	19,924	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	31,199,645	0.000000	0.000000	446,638	60.00
65.00 06500 RESPIRATORY THERAPY	0	5,200,727	0.000000	0.000000	18,921	65.00
66.00 06600 PHYSICAL THERAPY	0	980,455	0.000000	0.000000	10,078	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	474,725	0.000000	0.000000	3,735	67.00
68.00 06800 SPEECH PATHOLOGY	0	344,394	0.000000	0.000000	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	9,520,518	0.000000	0.000000	1,664	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,188,139	0.000000	0.000000	2,047	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	9,898,399	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	31,263,735	0.000000	0.000000	453,014	73.00
76.00 03140 RADIOLOGY	0	2,296,743	0.000000	0.000000	0	76.00
76.01 03950 WOUND CARE	0	8,686,440	0.000000	0.000000	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	1,238,699	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	2,436,120	0.000000	0.000000	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 09001 WOMENS CENTER	0	0	0.000000	0.000000	0	90.01
90.02 09002 PSYCH SERVICES	0	0	0.000000	0.000000	0	90.02
90.03 09003 OP BEHAVIORAL HEALTH	0	7,484,291	0.000000	0.000000	2,573	90.03
90.04 09004 DIABETES CENTER	0	0	0.000000	0.000000	0	90.04
91.00 09100 EMERGENCY	0	39,751,031	0.000000	0.000000	357,838	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3,471,143	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	308,846,930			1,348,219	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 12:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	260	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	184	0	0	0	73.00
76.00 03140 RADIOLOGY	0	0	0	0	0	76.00
76.01 03950 WOUND CARE	0	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 WOMENS CENTER	0	0	0	0	0	90.01
90.02 09002 PSYCH SERVICES	0	0	0	0	0	90.02
90.03 09003 OP BEHAVIORAL HEALTH	0	0	0	0	0	90.03
90.04 09004 DIABETES CENTER	0	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	195	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	639	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 12:53 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03140 CARDIOLOGY	0	0	76.00
76.01	03950 WOUND CARE	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	90.04
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: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.252781	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.062572	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210094	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.191112	0	0	0	0	56.00
57.00	05700	CT SCAN	0.046901	0	0	0	0	57.00
58.00	05800	MRI	0.065591	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.121745	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.304994	260	0	0	79	65.00
66.00	06600	PHYSICAL THERAPY	0.714569	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331006	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.322912	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.203497	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.648350	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.339373	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380396	184	0	103	70	73.00
76.00	03140	CARDIOLOGY	0.517378	0	0	0	0	76.00
76.01	03950	WOUND CARE	0.248540	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.712077	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.170887	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0.000000	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0.000000	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.275074	0	0	0	0	90.03
90.04	09004	DIABETES CENTER	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.195260	195	0	0	38	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.749492	0	0	0	0	92.00
200.00		Subtotal (see instructions)		639	0	103	187	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (Line 200 +/- Line 201)		639	0	103	187	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/22/2016 12:53 pm
	Title XVIII	Subprovider - IPF	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		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	39		73.00
76.00 03140 CARDIOLOGY	0	0		76.00
76.01 03950 WOUND CARE	0	0		76.01
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOMENS CENTER	0	0		90.01
90.02 09002 PSYCH SERVICES	0	0		90.02
90.03 09003 OP BEHAVIORAL HEALTH	0	0		90.03
90.04 09004 DIABETES CENTER	0	0		90.04
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)	0	39		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (Line 200 +/- Line 201)	0	39		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140176
Component CCN: 145788

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

Worksheet D
Part IV
Date/Time Prepared:
11/22/2016 12:53 pm
PPS

Title XVIII

Skilled Nursing Facility

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0	0	0	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140176 Component CCN: 145788	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 12:53 pm PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	56,960,824	0.000000	0.000000	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	5,907,254	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	25,163,637	0.000000	0.000000	0 54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0 55.00
56.00 05600 RADIOISOTOPE	0	5,036,923	0.000000	0.000000	0 56.00
57.00 05700 CT SCAN	0	36,921,076	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	12,422,012	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	31,199,645	0.000000	0.000000	0 60.00
65.00 06500 RESPIRATORY THERAPY	0	5,200,727	0.000000	0.000000	0 65.00
66.00 06600 PHYSICAL THERAPY	0	980,455	0.000000	0.000000	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	474,725	0.000000	0.000000	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	344,394	0.000000	0.000000	0 68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0 70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	9,520,518	0.000000	0.000000	0 70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,188,139	0.000000	0.000000	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	9,898,399	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	31,263,735	0.000000	0.000000	0 73.00
76.00 03140 RADIOLOGY	0	2,296,743	0.000000	0.000000	0 76.00
76.01 03950 WOUND CARE	0	8,686,440	0.000000	0.000000	0 76.01
76.97 07697 CARDIAC REHABILITATION	0	1,238,699	0.000000	0.000000	0 76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	2,436,120	0.000000	0.000000	0 76.98
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0.000000	0.000000	0 90.00
90.01 09001 WOMENS CENTER	0	0	0.000000	0.000000	0 90.01
90.02 09002 PSYCH SERVICES	0	0	0.000000	0.000000	0 90.02
90.03 09003 OP BEHAVIORAL HEALTH	0	7,484,291	0.000000	0.000000	0 90.03
90.04 09004 DIABETES CENTER	0	0	0.000000	0.000000	0 90.04
91.00 09100 EMERGENCY	0	39,751,031	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3,471,143	0.000000	0.000000	0 92.00
200.00 Total (lines 50-199)	0	308,846,930			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140176 Component CCN: 145788	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part IV Date/Time Prepared: 11/22/2016 12:53 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03140 RADIOLOGY	0	0	0	0	0	76.00
76.01 03950 WOUND CARE	0	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 WOMENS CENTER	0	0	0	0	0	90.01
90.02 09002 PSYCH SERVICES	0	0	0	0	0	90.02
90.03 09003 OP BEHAVIORAL HEALTH	0	0	0	0	0	90.03
90.04 09004 DIABETES CENTER	0	0	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140176

Period: From 07/01/2015

Worksheet D

Component CCN: 145788

To 06/30/2016

Part IV

Date/Time Prepared: 11/22/2016 12:53 pm

Title XVIII

Skilled Nursing Facility

PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03140 CARDIOLOGY	0	0	76.00
76.01	03950 WOUND CARE	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	90.04
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 11/22/2016 12:53 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,091	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,091	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)		11,912	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)		6,596	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		16,823,863	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)		16,823,863	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		16,823,863	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,193.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,875,228	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)		7,875,228	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/22/2016 12:53 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	4,647,862	2,165	2,146.82	1,156	2,481,724		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					10,205,654		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					20,562,606		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)					849,237		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					801,749		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,650,986		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					18,911,620		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					2,179		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,193.94		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,601,595		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/22/2016 12:53 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	1,375,339	16,823,863	0.081749	2,601,595	212,678	90.00
91.00	Nursing School cost	0	16,823,863	0.000000	2,601,595	0	91.00
92.00	Allied health cost	0	16,823,863	0.000000	2,601,595	0	92.00
93.00	All other Medical Education	0	16,823,863	0.000000	2,601,595	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,262	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,262	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)		8,262	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,386	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		8,693,771	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)		8,693,771	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		8,693,771	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,052.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,510,692	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,510,692	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1	
		Component CCN: 14S176				Date/Time Prepared: 11/22/2016 12:53 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					317,803		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,828,495		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)					238,886		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					23,106		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					261,992		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,566,503		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176 Component CCN: 14S176		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/22/2016 12:53 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	827,182	8,693,771	0.095147	0	0	90.00
91.00	Nursing School cost	0	8,693,771	0.000000	0	0	91.00
92.00	Allied health cost	0	8,693,771	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,693,771	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176 Component CCN: 145788	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			0 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			0 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)			0 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)			0 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			0 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)			0 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			0 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1	
		Component CCN: 145788		Date/Time Prepared: 11/22/2016 12:53 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
	Intensive Care Type Inpatient Hospital Units				
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
	Cost Center Description				
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				49.00
	PASS THROUGH COST ADJUSTMENTS				
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST				
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY				
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				0 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				0.00 71.00
72.00	Program routine service cost (line 9 x line 71)				0 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				0 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				0 83.00
84.00	Program inpatient ancillary services (see instructions)				0 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				0 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140176 Component CCN: 145788		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/22/2016 12:53 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/22/2016 12:53 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		13,235,203	30.00
31.00	03100	INTENSIVE CARE UNIT		3,539,607	31.00
40.00	04000	SUBPROVIDER - IPF		17,616	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.253186	5,030,690	1,273,700 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.062572	594,458	37,196 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210815	3,044,858	641,902 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0.191112	301,742	57,667 56.00
57.00	05700	CT SCAN	0.046901	4,262,362	199,909 57.00
58.00	05800	MRI	0.065591	718,439	47,123 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.121745	7,337,425	893,295 60.00
65.00	06500	RESPIRATORY THERAPY	0.304994	2,361,356	720,199 65.00
66.00	06600	PHYSICAL THERAPY	0.722193	607,776	438,932 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331006	276,366	91,479 67.00
68.00	06800	SPEECH PATHOLOGY	0.322912	208,558	67,346 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.204060	49,185	10,037 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.648350	2,004,901	1,299,878 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.339373	2,882,795	978,343 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380396	6,670,080	2,537,272 73.00
76.00	03140	CARDIOLOGY	0.517378	84,292	43,611 76.00
76.01	03950	WOUND CARE	0.249498	15,720	3,922 76.01
76.97	07697	CARDIAC REHABILITATION	0.712439	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.170887	2,202	376 76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	09001	WOMENS CENTER	0.000000	0	0 90.01
90.02	09002	PSYCH SERVICES	0.000000	0	0 90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.275074	0	0 90.03
90.04	09004	DIABETES CENTER	0.000000	0	0 90.04
91.00	09100	EMERGENCY	0.195692	4,412,376	863,467 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.749492	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		40,865,581	10,205,654 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		40,865,581	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/22/2016 12:53 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		3,640,923		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.253186	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.062572	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.210815	9,869	2,081	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.191112	0	0	56.00
57.00	05700 CT SCAN	0.046901	21,918	1,028	57.00
58.00	05800 MRI	0.065591	19,924	1,307	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.121745	446,638	54,376	60.00
65.00	06500 RESPIRATORY THERAPY	0.304994	18,921	5,771	65.00
66.00	06600 PHYSICAL THERAPY	0.722193	10,078	7,278	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.331006	3,735	1,236	67.00
68.00	06800 SPEECH PATHOLOGY	0.322912	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.204060	1,664	340	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.648350	2,047	1,327	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.339373	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.380396	453,014	172,325	73.00
76.00	03140 CARDIOLOGY	0.517378	0	0	76.00
76.01	03950 WOUND CARE	0.249498	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.712439	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.170887	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOMENS CENTER	0.000000	0	0	90.01
90.02	09002 PSYCH SERVICES	0.000000	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0.275074	2,573	708	90.03
90.04	09004 DIABETES CENTER	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.195692	357,838	70,026	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.749492	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,348,219	317,803	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,348,219		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,635,704	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,072,743	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)		345,741	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		66.05	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.63	30.00
31.00	Percentage of Medicaid patient days (see instructions)		12.43	31.00
32.00	Sum of lines 30 and 31		15.06	32.00
33.00	Allowable disproportionate share percentage (see instructions)		2.54	33.00
34.00	Disproportionate share adjustment (see instructions)		93,399	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	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)	937,598	726,961	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	236,326	544,228	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	780,554		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	15,928,141		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		15,928,141	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,211,584	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		17,139,725	59.00
60.00	Primary payer payments		6,944	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		17,132,781	61.00
62.00	Deductibles billed to program beneficiaries		1,729,952	62.00
63.00	Coinurance billed to program beneficiaries		50,988	63.00
64.00	Allowable bad debts (see instructions)		400,549	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		260,357	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		291,917	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,612,198	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)		-11,811	70.93
70.94	HRR adjustment amount (see instructions)		-50,537	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 12:53 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)		15,549,850		71.00
71.01	Sequestration adjustment (see instructions)		310,997		71.01
72.00	Interim payments		15,133,283		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)		105,570		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		18,753		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0		100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0		102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0		104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet DSH Date/Time Prepared: 11/22/2016 12:53 pm
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		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Hospital Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.63	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	12.43	0.00			12.43	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	15.06	0.00			12.43	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	66.05	0.00			66.05	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	2.54	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	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
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	346	0			346	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	239	0			239	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	3	0			3	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)	1,162	0			1,162	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,750	0			1,750	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	14,077	0			14,077	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	14,077	0			14,077	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	12.43	0.00			12.43	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140176		Period: From 07/01/2015 To 06/30/2016		Worksheet DSH Date/Time Prepared: 11/22/2016 12:53 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	2.54		0.00	True	29.00
30.00	Line 28 or 29 as applicable		2.54		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet DSH Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS

		Revised	
		Percentage	
		6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	4.17	29.00
30.00	Line 28 or 29 as applicable	4.17	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.	0.00	31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140176

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/22/2016 12:53 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,635,704	0	3,635,704		3,635,704	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,072,743	0		11,072,743	11,072,743	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	345,741	0	94,902	250,839	345,741	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0254	0.0254	0.0254	0.0254		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	93,399	0	23,087	70,312	93,399	11.00
11.01	Uncompensated care payments	36.00	780,554	0	780,554	0	780,554	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,928,141	0	4,534,247	11,393,894	15,928,141	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,928,141	0	4,534,247	11,393,894	15,928,141	15.00
16.00	Payment for inpatient program capital	50.00	1,211,584	0	299,168	912,416	1,211,584	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140176

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/22/2016 12:53 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	4,833,415	12,306,310	17,139,725	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,178,865	0	290,674	888,192	1,178,866	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	32,719	0	8,494	24,225	32,719	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,211,584	0	299,168	912,416	1,211,584	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS

	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00				1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,635,704	3,635,704		1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,072,743		11,072,743	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00	345,741	94,902	250,839	2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	2.01	
3.00	Operating outlier reconciliation	2.01	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	4.00	
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	9.01	
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0254	0.0254	0.0254	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	93,399	23,087	70,312	11.00	
11.01	Uncompensated care payments	36.00	780,554	236,326	0	11.01	
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	15,928,141	3,990,019	11,938,122	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,928,141	3,990,019	11,938,122	15.00	
16.00	Payment for inpatient program capital	50.00	1,211,584	299,168	912,416	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	17.00	
17.01	Net organ acquisition cost	55.00	0	0	0	17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00	
19.00	SUBTOTAL			4,289,187	12,850,538	17,139,725	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 140176

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/22/2016 12:53 pm

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	1,178,865	290,674	888,191	1,178,865	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	32,719	8,494	24,225	32,719	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	1,211,584	299,168	912,416	1,211,584	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	-11,811	-17,436	5,625	-11,811	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-50,537	-50,537	0	-50,537	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		16,709	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		14,515,473	2.00
3.00	PPS payments		11,580,206	3.00
4.00	Outlier payment (see instructions)		32,692	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		16,709	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		46,207	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)		46,207	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		46,207	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		29,498	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)		16,709	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)		11,612,898	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		4,216	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,499,724	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)		9,125,667	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		9,125,667	30.00
31.00	Primary payer payments		2,196	31.00
32.00	Subtotal (line 30 minus line 31)		9,123,471	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		475,692	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		309,200	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		356,129	36.00
37.00	Subtotal (see instructions)		9,432,671	37.00
38.00	MSP-LCC reconciliation amount from PS&R		33	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)		9,432,638	40.00
40.01	Sequestration adjustment (see instructions)		188,653	40.01
41.00	Interim payments		9,155,093	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		88,892	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		39	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		187	2.00
3.00	PPS payments		156	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		39	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		103	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)		103	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		103	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		64	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)		39	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)		156	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		25	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)		170	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		170	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		170	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		170	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)		170	40.00
40.01	Sequestration adjustment (see instructions)		3	40.01
41.00	Interim payments		166	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140176 Component CCN: 145788	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			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)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140176

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

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2016 12:53 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		15,142,399		9,119,808	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	01/28/2016	35,285	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	01/28/2016	9,116		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)		-9,116		35,285	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)		15,133,283		9,155,093	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		105,570		88,892	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		15,238,853		9,243,985	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140176
Component CCN: 14S176

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

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2016 12:53 pm
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,759,388		166	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,759,388		166	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		97,069		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,856,457		167	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140176
Component CCN: 145788

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

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2016 12:53 pm
PPS

Title XVIII

Skilled Nursing
Facility

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		721		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		721		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		3,807	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		7,752	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		835	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		14,077	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		351,093,192	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		5,174,640	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)		783,657	8.00
9.00	Sequestration adjustment amount (see instructions)		15,673	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		767,984	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		826,310	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)		-58,326	32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140176 Component CCN: 14S176	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part II Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,030,745 1.00
2.00	Net IPF PPS Outlier Payments			23,077 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			22.573770 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,053,822 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,053,822 16.00
17.00	Primary payer payments			1,016 17.00
18.00	Subtotal (line 16 less line 17).			2,052,806 18.00
19.00	Deductibles			197,372 19.00
20.00	Subtotal (line 18 minus line 19)			1,855,434 20.00
21.00	Coinsurance			60,123 21.00
22.00	Subtotal (line 20 minus line 21)			1,795,311 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			152,359 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			99,033 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			128,511 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,894,344 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,894,344 31.00
31.01	Sequestration adjustment (see instructions)			37,887 31.01
32.00	Interim payments			1,759,388 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			97,069 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			23,077 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140176 Component CCN: 145788	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		1,132	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		736	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		736	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		736	15.00
15.01	Sequestration adjustment (see instructions)		15	15.01
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		721	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 140176

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

Worksheet G

Date/Time Prepared:
11/22/2016 12:53 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	28,000	0	0	0	1.00
2.00	Temporary investments	3,333,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,255,000	0	0	0	4.00
5.00	Other receivable	52,257,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,265,000	0	0	0	7.00
8.00	Prepaid expenses	346,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	77,484,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	219,885	0	0	0	12.00
13.00	Land improvements	3,212,830	0	0	0	13.00
14.00	Accumulated depreciation	-2,080,648	0	0	0	14.00
15.00	Buildings	75,711,387	0	0	0	15.00
16.00	Accumulated depreciation	-53,003,430	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	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	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	56,618,714	0	0	0	23.00
24.00	Accumulated depreciation	-49,464,311	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	9,336,651	0	0	0	27.00
28.00	Accumulated depreciation	-4,432,078	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	36,119,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	26,822,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,340,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,162,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	145,765,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,387,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,044,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,987,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,418,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	71,205,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,958,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	73,163,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	89,581,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	56,184,000	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	0	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)	56,184,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	145,765,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140176

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

Worksheet G-1

Date/Time Prepared:
11/22/2016 12:53 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		53,101,000			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,703,000				2.00
3.00	Total (sum of line 1 and line 2)		58,804,000			0	3.00
4.00	CHANGES IN TEMP RESTRICTED ASSETS	86,000		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		86,000			0	10.00
11.00	Subtotal (line 3 plus line 10)		58,890,000			0	11.00
12.00	CHANGES IN UNREALIZED LOSSES	1,076,000		0		0	12.00
13.00	TRANSFER TO AFFILIATED ORGANIZATION	1,630,000		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)		2,706,000			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		56,184,000			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	CHANGES IN TEMP RESTRICTED ASSETS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	CHANGES IN UNREALIZED LOSSES		0				12.00
13.00	TRANSFER TO AFFILIATED ORGANIZATION		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140176

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/22/2016 12:53 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	22,867,908		22,867,908	1.00
2.00	SUBPROVIDER - IPF	12,752,863		12,752,863	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	0		0	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)	35,620,771		35,620,771	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,625,491		6,625,491	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,625,491		6,625,491	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,246,262		42,246,262	17.00
18.00	Ancillary services	79,897,143	178,243,322	258,140,465	18.00
19.00	Outpatient services	9,386,587	41,319,878	50,706,465	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CRISIS PROGRAM	0	1,786,036	1,786,036	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	131,529,992	221,349,236	352,879,228	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		119,311,330		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)		119,311,330		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140176

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

Worksheet G-3

Date/Time Prepared:
11/22/2016 12:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	352,879,228	1.00
2.00	Less contractual allowances and discounts on patients' accounts	232,925,313	2.00
3.00	Net patient revenues (line 1 minus line 2)	119,953,915	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	119,311,330	4.00
5.00	Net income from service to patients (line 3 minus line 4)	642,585	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	-138,373	6.00
7.00	Income from investments	451,512	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	4,747,673	24.00
24.01	ROUNDING	-397	24.01
25.00	Total other income (sum of lines 6-24)	5,060,415	25.00
26.00	Total (line 5 plus line 25)	5,703,000	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,703,000	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140176	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/22/2016 12:53 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,178,865	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		32,719	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)		38.46	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,211,584	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00