

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: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/28/2016 1:07 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/28/2016 Time: 1:07 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ALEXIAN BROTHERS BEHAVIORAL HEALTH (144031) 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.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	24,985	34,372	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	24,985	34,372	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 144031		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 12:57 pm			
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1650 MOON LAKE BOULEVARD			PO Box:							1.00	
2.00	City: HOFFMAN ESTATES			State: IL		Zip Code: 60194-		County: COOK			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII	XIX		
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			ALEXIAN BROTHERS BEHAVIORAL HEALTH	144031	16974	4	06/28/1990	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		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)						1				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						0		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 days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 12:57 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	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00		61.20	
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					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.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX		
		1.00	2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00			95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00			97.00
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)					106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	734,859	0			118.01
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144031		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 12:57 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	149019			140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ALEXIAN BROTHERS HOSPITAL NETWORK	Contractor's Name: WPS		Contractor's Number: 05001		141.00	
142.00	Street: 3040 SALT CREEK LANE	PO Box:				142.00	
143.00	City: ARLINGTON HEIGHTS	State: IL	Zip Code: 60005				143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC	N	N	N	N	161.00	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/28/2016 12:57 pm
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			171.00
			N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 12:57 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)	N	11/03/2016	N	11/03/2016
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/28/2016 12:57 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		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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	06/30/2015	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE REIMBURSEMENT&CONSULTING			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023		TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 144031

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

Worksheet S-2
Part II
Date/Time Prepared:
11/28/2016 12:57 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144031

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2016 12:57 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	141	51,465	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)		141	51,465	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		141	51,465	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		141				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: 144031

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2016 12:57 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	15,928	1,393	46,566			1.00
2.00 HMO and other (see instructions)	1,908	2,592				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	15,928	1,393	46,566			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)	15,928	1,393	46,566	0.00	570.39	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	570.39	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144031

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2016 12:57 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	1,115	146	5,692	1.00
2.00 HMO and other (see instructions)			154	373		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,115	146	5,692	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						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: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part II Date/Time Prepared: 11/28/2016 12:57 pm
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	Worksheet A Line Number	Amount Reported	Recl assifi 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	39,116,447	0	39,116,447	0.00	0.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		11,868,145	0	11,868,145	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		0	0	0		17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0		18.00
19.00	Excluded areas		0	0	0		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		0	0	0		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		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	55,279	0	55,279	0.00	0.00
27.00	Administrative & General	5.00	5,247,292	0	5,247,292	0.00	0.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	145,756	0	145,756	0.00	0.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	101,934	0	101,934	0.00	0.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	332,614	-61,735	270,879	0.00	0.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	61,735	61,735	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,270,452	0	1,270,452	0.00	0.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 144031

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

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2016 12:57 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	16.00 462,948	0	462,948	0.00	0.00	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 144031

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

Worksheet S-3
Part III
Date/Time Prepared:
11/28/2016 12:57 pm

	Worksheet A	Amount	Recl assi fi cation	Adjusted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries (from Worksheet A-6)	Salaries (col . 2 ± col . 3)	Related to Salaries in col . 4	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)	39,116,447	0	39,116,447	0.00	0.00	1.00
2.00	Excluded area salaries (see instructions)	11,868,145	0	11,868,145	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	27,248,302	0	27,248,302	0.00	0.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	0	0	0	0.00	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	27,248,302	0	27,248,302	0.00	0.00	6.00
7.00	Total overhead cost (see instructions)	7,616,275	0	7,616,275	0.00	0.00	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2016 12:57 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 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			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			0 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)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			0 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			0 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 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			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			0 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 144031

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

Worksheet S-3
Part V
Date/Time Prepared:
11/28/2016 12:57 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	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144031

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

Worksheet A
Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		976,514	976,514	781,574	1,758,088	1.00
2.00	00200		0	0	192,283	192,283	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	55,279	4,228,367	4,283,646	0	4,283,646	4.00
5.00	00500	5,247,292	19,855,264	25,102,556	-1,836,864	23,265,692	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	145,756	940,339	1,086,095	-105,357	980,738	7.00
8.00	00800	0	0	0	195,000	195,000	8.00
9.00	00900	101,934	1,004,284	1,106,218	-195,000	911,218	9.00
10.00	01000	332,614	1,924,052	2,256,666	-418,852	1,837,814	10.00
11.00	01100	0	0	0	418,852	418,852	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	1,270,452	115,287	1,385,739	0	1,385,739	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	462,948	416,121	879,069	0	879,069	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,333,814	2,715,058	18,048,872	512,224	18,561,096	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	27,409	27,409	341	27,750	54.00
60.00	06000	0	168,860	168,860	55,824	224,684	60.00
66.00	06600	141,309	28,371	169,680	3,381	173,061	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	1,645,751	1,645,751	55,991	1,701,742	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	418,912	123,602	542,514	21,913	564,427	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	3,737,992	476,170	4,214,162	316,464	4,530,626	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
118.00		27,248,302	34,645,449	61,893,751	-2,226	61,891,525	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	950,018	599,095	1,549,113	1,927	1,551,040	191.00
192.00	19200	10,601,587	1,620,594	12,222,181	0	12,222,181	192.00
194.00	07950	105,585	8,747	114,332	299	114,631	194.00
194.01	07951	210,955	23,220	234,175	0	234,175	194.01
200.00		39,116,447	36,897,105	76,013,552	0	76,013,552	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144031

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

Worksheet A
Date/Time Prepared:
11/28/2016 12:57 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	2,386,080	4,144,168	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	107,253	299,536	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	279,548	4,563,194	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,582,717	21,682,975	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,088,771	2,069,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	195,000	8.00
9.00	00900	HOUSEKEEPING	0	911,218	9.00
10.00	01000	DIETARY	0	1,837,814	10.00
11.00	01100	CAFETERIA	-193,216	225,636	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,385,739	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,658	939,727	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	18,561,096	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,750	54.00
60.00	06000	LABORATORY	0	224,684	60.00
66.00	06600	PHYSICAL THERAPY	0	173,061	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,701,742	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	-37,200	527,227	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	PARTIAL HOSPITALIZATION	-23,979	4,506,647	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,085,198	63,976,723	118.00
NONREIMBURSABLE COST CENTERS					
191.00	19100	RESEARCH	-209,839	1,341,201	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-451,513	11,770,668	192.00
194.00	07950	DUI PROGRAM	0	114,631	194.00
194.01	07951	IPPS	0	234,175	194.01
200.00		TOTAL (SUM OF LINES 118-199)	1,423,846	77,437,398	200.00

RECLASSIFICATIONS

Provider CCN: 144031

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

Worksheet A-6

Date/Time Prepared:
11/28/2016 12:57 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTAL EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	123,908	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	123,908	
B - BUILDING RENTAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,093	1.00
	TOTALS		0	7,093	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	61,735	357,117	1.00
	TOTALS		61,735	357,117	
D - PFS RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	528,294	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	341	2.00
3.00	LABORATORY	60.00	0	55,824	3.00
4.00	PHYSICAL THERAPY	66.00	0	3,381	4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	55,991	5.00
6.00	ELECTROSHOCK THERAPY	76.00	0	24,394	6.00
7.00	PARTIAL HOSPITALIZATION	93.00	0	323,557	7.00
8.00	RESEARCH	191.00	0	1,927	8.00
9.00	DUI PROGRAM	194.00	0	299	9.00
	TOTALS		0	994,008	
E - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	195,000	1.00
	TOTALS		0	195,000	
F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	842,856	1.00
	TOTALS		0	842,856	
H - EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	192,283	1.00
	TOTALS		0	192,283	
500.00	Grand Total: Increases		61,735	2,712,265	500.00

RECLASSIFICATIONS

Provider CCN: 144031

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

Worksheet A-6

Date/Time Prepared:
11/28/2016 12:57 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENTAL EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	105,357	10		1.00
2.00	ELECTROSHOCK THERAPY	76.00	0	2,481	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	16,070	0		3.00
	TOTALS		0	123,908			
B - BUILDING RENTAL							
1.00	PARTIAL HOSPITALIZATION	93.00	0	7,093	10		1.00
	TOTALS		0	7,093			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	61,735	357,117	0		1.00
	TOTALS		61,735	357,117			
D - PFS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	994,008	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
	TOTALS		0	994,008			
E - LAUNDRY							
1.00	HOUSEKEEPING	9.00	0	195,000	0		1.00
	TOTALS		0	195,000			
F - INTEREST EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	842,856	11		1.00
	TOTALS		0	842,856			
H - EQUIPMENT DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	192,283	9		1.00
	TOTALS		0	192,283			
500.00	Grand Total: Decreases		61,735	2,712,265			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

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

Worksheet A-7
Part I
Date/Time Prepared:
11/28/2016 12:57 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,540,000	0	0	0	1.00
2.00	Land Improvements	102,691	164,984	0	164,984	2.00
3.00	Buildings and Fixtures	21,305,100	0	0	0	3.00
4.00	Building Improvements	1,442,716	127,964	0	127,964	4.00
5.00	Fixed Equipment	275,765	164,850	0	164,850	5.00
6.00	Movable Equipment	2,033,579	277,823	0	277,823	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,699,851	735,621	0	735,621	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,699,851	735,621	0	735,621	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,540,000	0			1.00
2.00	Land Improvements	267,675	0			2.00
3.00	Buildings and Fixtures	21,305,100	0			3.00
4.00	Building Improvements	1,570,548	0			4.00
5.00	Fixed Equipment	440,615	0			5.00
6.00	Movable Equipment	2,157,239	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	27,281,177	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	27,281,177	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

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

Worksheet A-7
Part II
Date/Time Prepared:
11/28/2016 12:57 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	976,514	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)	976,514	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	976,514				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	976,514				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144031

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

Worksheet A-7
Part III
Date/Time Prepared:
11/28/2016 12:57 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	25,123,938	0	25,123,938	0.920926	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,157,239	0	2,157,239	0.079074	0	2.00
3.00	Total (sum of lines 1-2)	27,281,177	0	27,281,177	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	2,736,777	131,001	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	299,536	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,036,313	131,001	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	1,276,390	0	0	0	4,144,168	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	299,536	2.00
3.00	Total (sum of lines 1-2)	1,276,390	0	0	0	4,443,704	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144031

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

Worksheet A-8

Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			3.00	4.00			
1.00	2.00	3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2		0			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	3,451,356				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-193,216	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	-1,339	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	*** Cost Center Deleted ***	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	A	-17,848	CAP REL COSTS-BLDG & FIXT		1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	107,253	CAP REL COSTS-MVBLE EQUIP		2.00	9	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	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	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 MISC INCOME	B	-48,944	ADMINISTRATIVE & GENERAL		5.00	0	33.00
33.01 MISC INCOME	B	23,218	PARTIAL HOSPITALIZATION		93.00	0	33.01

Provider CCN: 144031 Period: From 07/01/2015 To 06/30/2016 Worksheet A-8
 Date/Time Prepared: 11/28/2016 12:57 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	
33.02 RESEARCH HBP	A	-209,839	RESEARCH	191.00	0 33.02
33.03 GROUP PRACTICE HBP	A	-678,465	PHYSICIANS' PRIVATE OFFICES	192.00	0 33.03
33.05		0		0.00	0 33.05
34.00 BUSINESS DEVELOPMENT/MARKETING	A	-308,733	ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00 BUSINESS DEVELOPMENT OTHER	B	-86,975	ADMINISTRATIVE & GENERAL	5.00	0 35.00
INCO					
36.00 ECT OTHER INCOME	B	-37,200	ELECTROSHOCK THERAPY	76.00	0 36.00
37.00 SCHOOL REIMBURSEMENT	A	-515,700	ADMINISTRATIVE & GENERAL	5.00	0 37.00
38.00 OTHER INCOME - AFTERCARE	B	-47,197	PARTIAL HOSPITALIZATION	93.00	0 38.00
39.00 REAL ESTATE TAXES	A	-8,500	ADMINISTRATIVE & GENERAL	5.00	0 39.00
40.01 OTHER PRO FEES	B	-2,325	ADMINISTRATIVE & GENERAL	5.00	0 40.01
40.03 DONATIONS	A	-1,700	ADMINISTRATIVE & GENERAL	5.00	0 40.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,423,846			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: 144031

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2016 12:57 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	ABHN NON CAP	10,024,393	10,634,233 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ABHS CAPITAL	46,968	0 2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	433,534	0 3.00
3.01	16.00	MEDICAL RECORDS & LIBRARY	ICD 10 TRAINING	61,997	0 3.01
3.02	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAPITAL	1,923,426	0 3.02
3.03	0.00			0	0 3.03
3.04	7.00	OPERATION OF PLANT	CLINICAL ENGINEERING	1,088,771	0 3.04
3.05	0.00			0	0 3.05
3.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	EXECUTIVE BENEFITS	279,548	0 3.06
3.07	0.00			0	0 3.07
3.08	0.00			0	0 3.08
3.09	0.00			0	0 3.09
3.10	0.00			0	0 3.10
3.11	192.00	PHYSICIANS' PRIVATE OFFICES	ABMP NON CAPITAL	226,952	0 3.11
3.12	0.00			0	0 3.12
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,085,589	10,634,233 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	ABHS	100.00	0.00	6.00
7.00			0.00	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: 144031

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2016 12:57 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	-609,840	0		1.00
2.00	46,968	9		2.00
3.00	433,534	11		3.00
3.01	61,997	0		3.01
3.02	1,923,426	9		3.02
3.03	0	9		3.03
3.04	1,088,771	0		3.04
3.05	0	0		3.05
3.06	279,548	0		3.06
3.07	0	9		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	226,952	0		3.11
3.12	0	0		3.12
4.00	0	0		4.00
5.00	3,451,356			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			6.00
7.00			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: 144031

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2016 12:57 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	5.00	DR. A	91,178	0	91,178	200,000	2,080	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			91,178	0	91,178		2,080	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	5.00	DR. A	200,000	10,000	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			200,000	10,000	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	5.00	DR. A	0	200,000	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	200,000	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2016 12:57 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	4,144,168	4,144,168			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	299,536		299,536		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,563,194	0	0	4,563,194	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	21,682,975	1,276,822	92,287	612,999	23,665,083
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	2,069,509	19,440	1,405	17,028	2,107,382
8.00 00800	LAUNDRY & LINEN SERVICE	195,000	8,629	624	0	204,253
9.00 00900	HOUSEKEEPING	911,218	4,852	351	11,908	928,329
10.00 01000	DIETARY	1,837,814	54,444	3,935	31,645	1,927,838
11.00 01100	CAFETERIA	225,636	88,015	6,362	7,212	327,225
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	1,385,739	0	0	148,417	1,534,156
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	939,727	34,711	2,509	54,083	1,031,030
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	18,561,096	1,943,951	140,506	1,791,315	22,436,868
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	27,750	0	0	0	27,750
60.00 06000	LABORATORY	224,684	0	0	0	224,684
66.00 06600	PHYSICAL THERAPY	173,061	0	0	16,508	189,569
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,701,742	14,816	1,071	0	1,717,629
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	527,227	20,058	1,450	48,938	597,673
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
93.00 04950	PARTIAL HOSPITALIZATION	4,506,647	180,654	13,057	436,680	5,137,038
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,976,723	3,646,392	263,557	3,176,733	62,056,507
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	1,341,201	6,708	485	110,983	1,459,377
192.00 19200	PHYSICIANS' PRIVATE OFFICES	11,770,668	491,068	35,494	1,238,499	13,535,729
194.00 07950	DUI PROGRAM	114,631	0	0	12,335	126,966
194.01 07951	IPPS	234,175	0	0	24,644	258,819
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	77,437,398	4,144,168	299,536	4,563,194	77,437,398

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2016 12:57 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	23,665,083					5.00
6.00	00600	0	0				6.00
7.00	00700	927,455	0	3,034,837			7.00
8.00	00800	89,891	0	9,195	303,339		8.00
9.00	00900	408,556	0	5,170	0	1,342,055	9.00
10.00	01000	848,438	0	58,017	0	25,778	10.00
11.00	01100	144,011	0	93,792	0	41,674	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	675,179	0	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	453,754	0	36,989	0	16,435	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,874,415	0	2,071,551	303,339	920,430	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	12,213	0	0	0	0	54.00
60.00	06000	98,883	0	0	0	0	60.00
66.00	06600	83,429	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	755,925	0	15,788	0	7,015	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	263,035	0	21,375	0	9,497	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	2,260,800	0	192,512	0	85,537	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		16,895,984	0	2,504,389	303,339	1,106,366	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	642,269	0	7,148	0	3,176	191.00
192.00	19200	5,957,047	0	523,300	0	232,513	192.00
194.00	07950	55,877	0	0	0	0	194.00
194.01	07951	113,906	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		23,665,083	0	3,034,837	303,339	1,342,055	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
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	2,860,071					10.00
11.00	01100		606,702				11.00
12.00	01200			0			12.00
13.00	01300		22,397		2,231,732		13.00
14.00	01400					0	14.00
15.00	01500						15.00
16.00	01600		11,871				16.00
17.00	01700						17.00
19.00	01900						19.00
20.00	02000						20.00
21.00	02100						21.00
22.00	02200						22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,860,071	334,840	0	1,760,412	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
66.00	06600	0	2,666	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	7,415	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	89,652	0	471,320	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,860,071	468,841	0	2,231,732	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	14,347	0	0	0	191.00
192.00	19200	0	115,794	0	0	0	192.00
194.00	07950	0	1,511	0	0	0	194.00
194.01	07951	0	6,209	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,860,071	606,702	0	2,231,732	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
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						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	0					15.00
16.00	01600	0	1,550,079				16.00
17.00	01700	0	0	0			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0		0	20.00
21.00	02100	0	0	0			21.00
22.00	02200	0	0	0			22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	810,730	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	544	0	0	0	54.00
60.00	06000	0	89,070	0	0	0	60.00
66.00	06600	0	5,394	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	89,336	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	38,753	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	516,252	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		0	1,550,079	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		0	1,550,079	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144031

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

Worksheet B
Part I
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Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV					
	21.00	22.00					
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		
12.00 01200	MAINTENANCE OF PERSONNEL				12.00		
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		
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00		
20.00 02000	NURSING SCHOOL				20.00		
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00		
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0		22.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	0	41,372,656	0	41,372,656	30.00
ANCILLARY SERVICE COST CENTERS							
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	40,507	0	40,507	54.00
60.00 06000	LABORATORY	0	0	412,637	0	412,637	60.00
66.00 06600	PHYSICAL THERAPY	0	0	281,058	0	281,058	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	2,585,693	0	2,585,693	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	0	937,748	0	937,748	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699	LITHOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	0	8,753,111	0	8,753,111	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	54,383,410	0	54,383,410	118.00
NONREIMBURSABLE COST CENTERS							
191.00 19100	RESEARCH	0	0	2,126,317	0	2,126,317	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	20,364,383	0	20,364,383	192.00
194.00 07950	DUI PROGRAM	0	0	184,354	0	184,354	194.00
194.01 07951	IPPS	0	0	378,934	0	378,934	194.01
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	77,437,398	0	77,437,398	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/28/2016 12:57 pm
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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	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,276,822	92,287	1,369,109	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	19,440	1,405	20,845	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	8,629	624	9,253	8.00
9.00 00900	HOUSEKEEPING	0	4,852	351	5,203	9.00
10.00 01000	DIETARY	0	54,444	3,935	58,379	10.00
11.00 01100	CAFETERIA	0	88,015	6,362	94,377	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	34,711	2,509	37,220	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,943,951	140,506	2,084,457	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	14,816	1,071	15,887	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	20,058	1,450	21,508	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	180,654	13,057	193,711	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,646,392	263,557	3,909,949	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	0	6,708	485	7,193	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	491,068	35,494	526,562	192.00
194.00 07950	DUI PROGRAM	0	0	0	0	194.00
194.01 07951	IPPS	0	0	0	0	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	4,144,168	299,536	4,443,704	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/28/2016 12:57 pm
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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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,369,109				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	53,656	0	74,501		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,200	0	226	14,679	8.00
9.00	00900	HOUSEKEEPING	23,636	0	127	0	28,966
10.00	01000	DIETARY	49,085	0	1,424	0	556
11.00	01100	CAFETERIA	8,331	0	2,302	0	899
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	39,061	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	26,251	0	908	0	355
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	571,277	0	50,854	14,679	19,867
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	707	0	0	0	0
60.00	06000	LABORATORY	5,721	0	0	0	0
66.00	06600	PHYSICAL THERAPY	4,827	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	43,733	0	388	0	151
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03320	ELECTROSHOCK THERAPY	15,217	0	525	0	205
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04950	PARTIAL HOSPITALIZATION	130,794	0	4,726	0	1,846
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	977,496	0	61,480	14,679	23,879
NONREIMBURSABLE COST CENTERS							
191.00	19100	RESEARCH	37,157	0	175	0	69
192.00	19200	PHYSICIANS' PRIVATE OFFICES	344,633	0	12,846	0	5,018
194.00	07950	DUI PROGRAM	3,233	0	0	0	0
194.01	07951	IPPS	6,590	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,369,109	0	74,501	14,679	28,966

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/28/2016 12:57 pm		
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY
		10.00	11.00	12.00	13.00	14.00
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	109,444				10.00
11.00	01100	0	105,909			11.00
12.00	01200	0	0	0		12.00
13.00	01300	0	3,910	0	42,971	13.00
14.00	01400	0	0	0	0	14.00
15.00	01500	0	0	0	0	15.00
16.00	01600	0	2,072	0	0	16.00
17.00	01700	0	0	0	0	17.00
19.00	01900	0	0	0	0	19.00
20.00	02000	0	0	0	0	20.00
21.00	02100	0	0	0	0	21.00
22.00	02200	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	109,444	58,451	0	33,896	30.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	0	0	0	0	54.00
60.00	06000	0	0	0	0	60.00
66.00	06600	0	465	0	0	66.00
69.00	06900	0	0	0	0	69.00
73.00	07300	0	0	0	0	73.00
74.00	07400	0	0	0	0	74.00
76.00	03320	0	1,294	0	0	76.00
76.97	07697	0	0	0	0	76.97
76.98	07698	0	0	0	0	76.98
76.99	07699	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200					92.00
93.00	04950	0	15,650	0	9,075	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		109,444	81,842	0	42,971	118.00
NONREIMBURSABLE COST CENTERS						
191.00	19100	0	2,505	0	0	191.00
192.00	19200	0	20,214	0	0	192.00
194.00	07950	0	264	0	0	194.00
194.01	07951	0	1,084	0	0	194.01
200.00						200.00
201.00		0	0	0	0	201.00
202.00		109,444	105,909	0	42,971	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet B Part II Date/Time Prepared: 11/28/2016 12:57 pm		
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL
		15.00	16.00	17.00	19.00	20.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	66,806		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	34,963	0	30.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23	0	54.00
60.00	06000	LABORATORY	0	3,836	0	60.00
66.00	06600	PHYSICAL THERAPY	0	232	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,848	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	1,669	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	22,235	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	66,806	0	118.00
NONREIMBURSABLE COST CENTERS						
191.00	19100	RESEARCH	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	DUI PROGRAM	0	0	0	194.00
194.01	07951	IPPS	0	0	0	194.01
200.00		Cross Foot Adjustments			0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	66,806	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144031

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

Worksheet B
Part II
Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
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
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
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
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0		22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS		2,977,888	0	2,977,888
ANCILLARY SERVICE COST CENTERS					
54.00 05400	RADIOLOGY-DIAGNOSTIC		730	0	730
60.00 06000	LABORATORY		9,557	0	9,557
66.00 06600	PHYSICAL THERAPY		5,524	0	5,524
69.00 06900	ELECTROCARDIOLOGY		0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS		64,007	0	64,007
74.00 07400	RENAL DIALYSIS		0	0	0
76.00 03320	ELECTROSHOCK THERAPY		40,418	0	40,418
76.97 07697	CARDIAC REHABILITATION		0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY		0	0	0
76.99 07699	LITHOTRIPSY		0	0	0
OUTPATIENT SERVICE COST CENTERS					
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	
93.00 04950	PARTIAL HOSPITALIZATION		378,037	0	378,037
OTHER REIMBURSABLE COST CENTERS					
94.00 09400	HOME PROGRAM DIALYSIS		0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,476,161	0	3,476,161
NONREIMBURSABLE COST CENTERS					
191.00 19100	RESEARCH		47,099	0	47,099
192.00 19200	PHYSICIANS' PRIVATE OFFICES		909,273	0	909,273
194.00 07950	DUI PROGRAM		3,497	0	3,497
194.01 07951	IPPS		7,674	0	7,674
200.00	Cross Foot Adjustments	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	4,443,704	0	4,443,704

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1

Date/Time Prepared:
11/28/2016 12:57 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	127,270				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		127,270			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	39,061,168		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	39,212	39,212	5,247,292	-23,665,083	53,772,315
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	597	597	145,756	0	2,107,382
8.00 00800	LAUNDRY & LINEN SERVICE	265	265	0	0	204,253
9.00 00900	HOUSEKEEPING	149	149	101,934	0	928,329
10.00 01000	DIETARY	1,672	1,672	270,879	0	1,927,838
11.00 01100	CAFETERIA	2,703	2,703	61,735	0	327,225
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	1,270,452	0	1,534,156
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,066	1,066	462,948	0	1,031,030
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	59,700	59,700	15,333,814	0	22,436,868
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	27,750
60.00 06000	LABORATORY	0	0	0	0	224,684
66.00 06600	PHYSICAL THERAPY	0	0	141,309	0	189,569
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	455	455	0	0	1,717,629
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03320	ELECTROSHOCK THERAPY	616	616	418,912	0	597,673
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00 04950	PARTIAL HOSPITALIZATION	5,548	5,548	3,737,992	0	5,137,038
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	111,983	111,983	27,193,023	-23,665,083	38,391,424
NONREIMBURSABLE COST CENTERS						
191.00 19100	RESEARCH	206	206	950,018	0	1,459,377
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,081	15,081	10,601,587	0	13,535,729
194.00 07950	DUI PROGRAM	0	0	105,585	0	126,966
194.01 07951	IPPS	0	0	210,955	0	258,819
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	4,144,168	299,536	4,563,194		23,665,083
203.00	Unit cost multiplier (Wkst. B, Part I)	32.562018	2.353548	0.116822		0.440098
204.00	Cost to be allocated (per Wkst. B, Part II)			0		1,369,109
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.025461

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1

Date/Time Prepared:
11/28/2016 12:57 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	0					6.00
7.00	00700		87,461				7.00
8.00	00800		265	100			8.00
9.00	00900	0	149		87,047		9.00
10.00	01000		1,672		1,672	142,158	10.00
11.00	01100		2,703		2,703	0	11.00
12.00	01200		0		0	0	12.00
13.00	01300		0		0	0	13.00
14.00	01400		0		0	0	14.00
15.00	01500		0		0	0	15.00
16.00	01600		1,066		1,066	0	16.00
17.00	01700		0		0	0	17.00
19.00	01900		0		0	0	19.00
20.00	02000		0		0	0	20.00
21.00	02100		0		0	0	21.00
22.00	02200		0		0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	59,700	100	59,700	142,158	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
66.00	06600	0	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	455	0	455	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	0	616	0	616	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	0	5,548	0	5,548	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		0	72,174	100	71,760	142,158	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	0	206	0	206	0	191.00
192.00	19200	0	15,081	0	15,081	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		0	3,034,837	303,339	1,342,055	2,860,071	202.00
203.00		0.000000	34.699317	3,033.390000	15.417590	20.118959	203.00
204.00		0	74,501	14,679	28,966	109,444	204.00
205.00		0.000000	0.851820	146.790000	0.332763	0.769876	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1

Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description		CAFETERIA (FULL TIME EQUIV'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	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						10.00
11.00	01100	47,784					11.00
12.00	01200	0	0				12.00
13.00	01300	1,764	0	695,402			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	935	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,372	0	548,540	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	0	0	60.00
66.00	06600	210	0	0	0	0	66.00
69.00	06900	0	0	0	0	0	69.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03320	584	0	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
93.00	04950	7,061	0	146,862	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		36,926	0	695,402	0	0	118.00
NONREIMBURSABLE COST CENTERS							
191.00	19100	1,130	0	0	0	0	191.00
192.00	19200	9,120	0	0	0	0	192.00
194.00	07950	119	0	0	0	0	194.00
194.01	07951	489	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		606,702	0	2,231,732	0	0	202.00
203.00		12.696760	0.000000	3.209269	0.000000	0.000000	203.00
204.00		105,909	0	42,971	0	0	204.00
205.00		2.216411	0.000000	0.061793	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1

Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
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
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
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	153,118,788					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	80,082,166	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	53,738	0	0	0	0	54.00
60.00 06000 LABORATORY	8,798,785	0	0	0	0	60.00
66.00 06600 PHYSICAL THERAPY	532,891	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS	8,825,053	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03320 ELECTROSHOCK THERAPY	3,828,250	0	0	0	0	76.00
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
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00 04950 PARTIAL HOSPITALIZATION	50,997,905	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	153,118,788	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950 DUI PROGRAM	0	0	0	0	0	194.00
194.01 07951 IPPS	0	0	0	0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,550,079	0	0	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.010123	0.000000	0.000000	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	66,806	0	0	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000436	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144031

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

Worksheet B-1
Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description		INTERNS & RESIDENTS	
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
		22.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03320	ELECTROSHOCK THERAPY	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIpsy	76.99
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04950	PARTIAL HOSPITALIZATION	93.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	DUI PROGRAM	194.00
194.01	07951	IPPS	194.01
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)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

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

Worksheet C
Part I
Date/Time Prepared:
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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	41,372,656		41,372,656	0	41,372,656	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	40,507		40,507	0	40,507	54.00
60.00	06000 LABORATORY	412,637		412,637	0	412,637	60.00
66.00	06600 PHYSICAL THERAPY	281,058	0	281,058	0	281,058	66.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,585,693		2,585,693	0	2,585,693	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	937,748		937,748	0	937,748	76.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	8,753,111		8,753,111	0	8,753,111	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	54,383,410	0	54,383,410	0	54,383,410	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	54,383,410	0	54,383,410	0	54,383,410	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	80,082,166		80,082,166		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,763	975	53,738	0.753787	54.00
60.00	06000	LABORATORY	8,770,187	28,598	8,798,785	0.046897	60.00
66.00	06600	PHYSICAL THERAPY	532,891	0	532,891	0.527421	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,256,334	568,719	8,825,053	0.292995	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
76.00	03320	ELECTROSHOCK THERAPY	2,087,940	1,740,310	3,828,250	0.244955	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	50,997,905	50,997,905	0.171637	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	99,782,281	53,336,507	153,118,788		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	99,782,281	53,336,507	153,118,788		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/28/2016 12:57 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.753787		54.00
60.00	06000 LABORATORY	0.046897		60.00
66.00	06600 PHYSICAL THERAPY	0.527421		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.292995		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03320 ELECTROSHOCK THERAPY	0.244955		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.171637		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
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: 144031

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

Worksheet C
Part I
Date/Time Prepared:
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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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	41,372,656		41,372,656	0	41,372,656 30.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	40,507		40,507	0	40,507 54.00	
60.00	06000 LABORATORY	412,637		412,637	0	412,637 60.00	
66.00	06600 PHYSICAL THERAPY	281,058	0	281,058	0	281,058 66.00	
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	2,585,693		2,585,693	0	2,585,693 73.00	
74.00	07400 RENAL DIALYSIS	0		0	0	0 74.00	
76.00	03320 ELECTROSHOCK THERAPY	937,748		937,748	0	937,748 76.00	
76.97	07697 CARDIAC REHABILITATION	0		0	0	0 76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98	
76.99	07699 LI THOTRI PSY	0		0	0	0 76.99	
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0 92.00	
93.00	04950 PARTIAL HOSPITALIZATION	8,753,111		8,753,111	0	8,753,111 93.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0 94.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	54,383,410	0	54,383,410	0	54,383,410 200.00	
201.00	Less Observation Beds	0		0		0 201.00	
202.00	Total (see instructions)	54,383,410	0	54,383,410	0	54,383,410 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144031

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	80,082,166		80,082,166			30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	52,763	975	53,738	0.753787	0.000000	54.00
60.00	06000 LABORATORY	8,770,187	28,598	8,798,785	0.046897	0.000000	60.00
66.00	06600 PHYSICAL THERAPY	532,891	0	532,891	0.527421	0.000000	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,256,334	568,719	8,825,053	0.292995	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03320 ELECTROSHOCK THERAPY	2,087,940	1,740,310	3,828,250	0.244955	0.000000	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.00	04950 PARTIAL HOSPITALIZATION	0	50,997,905	50,997,905	0.171637	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	99,782,281	53,336,507	153,118,788			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	99,782,281	53,336,507	153,118,788			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet C Part I Date/Time Prepared: 11/28/2016 12:57 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
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03320 ELECTROSHOCK THERAPY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
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: 144031		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part I Date/Time Prepared: 11/28/2016 12:57 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,977,888	0	2,977,888	46,566	63.95	30.00
200.00	Total (Lines 30-199)	2,977,888		2,977,888	46,566		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	15,928	1,018,596				
200.00	Total (Lines 30-199)	15,928	1,018,596				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 11/28/2016 12:57 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	730	53,738	0.013584	16,681	227	54.00
60.00	06000	LABORATORY	9,557	8,798,785	0.001086	2,550,808	2,770	60.00
66.00	06600	PHYSICAL THERAPY	5,524	532,891	0.010366	413,407	4,285	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,007	8,825,053	0.007253	3,408,558	24,722	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	40,418	3,828,250	0.010558	948,070	10,010	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	378,037	50,997,905	0.007413	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	498,273	73,036,622		7,337,524	42,014	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144031		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part III Date/Time Prepared: 11/28/2016 12:57 pm	
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	
200.00		Total (lines 30-199)	0	0	0	0	0	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,566	0.00	15,928	0	30.00	
200.00		Total (lines 30-199)	46,566		15,928	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144031

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	0	0	0	0	0	76.00
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
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
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: 144031

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,738	0.000000	0.000000	16,681	54.00
60.00	06000	LABORATORY	0	8,798,785	0.000000	0.000000	2,550,808	60.00
66.00	06600	PHYSICAL THERAPY	0	532,891	0.000000	0.000000	413,407	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,825,053	0.000000	0.000000	3,408,558	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	3,828,250	0.000000	0.000000	948,070	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	50,997,905	0.000000	0.000000	0	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	0	73,036,622			7,337,524	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144031

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	972	0	54.00
60.00	06000	LABORATORY	0	15,444	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	378,847	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0	969,370	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0	1,671,768	0	93.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00		Total (lines 50-199)	0	3,036,401	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/28/2016 12:57 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.753787	972	0	0	733	54.00
60.00	06000	LABORATORY	0.046897	15,444	0	0	724	60.00
66.00	06600	PHYSICAL THERAPY	0.527421	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292995	378,847	0	0	111,000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03320	ELECTROSHOCK THERAPY	0.244955	969,370	0	0	237,452	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04950	PARTIAL HOSPITALIZATION	0.171637	1,671,768	0	0	286,937	93.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00		Subtotal (see instructions)		3,036,401	0	0	636,846	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		3,036,401	0	0	636,846	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part V Date/Time Prepared: 11/28/2016 12:57 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				
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00 06000	LABORATORY	0	0	60.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03320	ELECTROSHOCK THERAPY	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00 04950	PARTIAL HOSPITALIZATION	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400	HOME PROGRAM DIALYSIS	0	0	94.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 11/28/2016 12:57 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)		46,566	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		46,566	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)		46,566	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		15,928	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)		41,372,656	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)		41,372,656	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)		41,372,656	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)		888.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,151,550	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		14,151,550	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 12:57 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,581,163	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				15,732,713	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				1,018,596	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				42,014	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,060,610	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				14,672,103	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: 144031		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 11/28/2016 12:57 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,977,888	41,372,656	0.071977	0	0	90.00
91.00	Nursing School cost	0	41,372,656	0.000000	0	0	91.00
92.00	Allied health cost	0	41,372,656	0.000000	0	0	92.00
93.00	All other Medical Education	0	41,372,656	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 12:57 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		46,566	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		46,566	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)		46,566	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)		1,393	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)		41,372,656	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)		41,372,656	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)		41,372,656	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)		888.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,237,639	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)		1,237,639	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/28/2016 12:57 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)
Title XIX		1.00	2.00	3.00	4.00	5.00
Hospital						
Cost						
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)					0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,237,639 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)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 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: 144031

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

Worksheet D-1
Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description	Cost	Title XIX		Hospital	Cost	
		Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,977,888	41,372,656	0.071977	0	0	90.00
91.00 Nursing School cost	0	41,372,656	0.000000	0	0	91.00
92.00 Allied health cost	0	41,372,656	0.000000	0	0	92.00
93.00 All other Medical Education	0	41,372,656	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/28/2016 12:57 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		27,100,550		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.753787	16,681	12,574	54.00
60.00	06000 LABORATORY	0.046897	2,550,808	119,625	60.00
66.00	06600 PHYSICAL THERAPY	0.527421	413,407	218,040	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.292995	3,408,558	998,690	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	0.244955	948,070	232,234	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.171637	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50-94 and 96-98)		7,337,524	1,581,163	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)		7,337,524		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 11/28/2016 12:57 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.753787	0	0	54.00
60.00	06000 LABORATORY	0.046897	0	0	60.00
66.00	06600 PHYSICAL THERAPY	0.527421	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.292995	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03320 ELECTROSHOCK THERAPY	0.244955	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.00	04950 PARTIAL HOSPITALIZATION	0.171637	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50-94 and 96-98)			0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0	201.00
202.00	Net Charges (line 200 minus line 201)			0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/28/2016 12:57 pm
		Title XVIII	Hospital	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)		636,846	2.00
3.00	PPS payments		731,198	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)		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)		731,198	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)		146,629	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)		584,569	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)		584,569	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		584,569	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)		53,956	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		35,071	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,361	36.00
37.00	Subtotal (see instructions)		619,640	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)		619,640	40.00
40.01	Sequestration adjustment (see instructions)		12,393	40.01
41.00	Interim payments		572,875	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		34,372	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 144031

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

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2016 12:57 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		12,755,621		572,875		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		329,400		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/22/2016	75,800		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)		75,800		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)		13,160,821		572,875		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		24,985		34,372		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		13,185,806		607,247		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part II Date/Time Prepared: 11/28/2016 12:57 pm
		Title XVII	Hospital	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)			13,882,752 1.00
2.00	Net IPF PPS Outlier Payments			76,158 2.00
3.00	Net IPF PPS ECT Payments			297,874 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)			127.229508 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)			14,256,784 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)			14,256,784 16.00
17.00	Primary payer payments			15,440 17.00
18.00	Subtotal (line 16 less line 17).			14,241,344 18.00
19.00	Deductibles			763,252 19.00
20.00	Subtotal (line 18 minus line 19)			13,478,092 20.00
21.00	Coinsurance			462,084 21.00
22.00	Subtotal (line 20 minus line 21)			13,016,008 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			675,225 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			438,896 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			89,510 25.00
26.00	Subtotal (sum of lines 22 and 24)			13,454,904 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)			13,454,904 31.00
31.01	Sequestration adjustment (see instructions)			269,098 31.01
32.00	Interim payments			13,160,821 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)			24,985 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			76,158 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: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2016 12:57 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		1,237,639		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,237,639	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,237,639	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		1,237,639	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		1,237,639	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 144031 Period: From 07/01/2015 To 06/30/2016 Worksheet G
 Date/Time Prepared: 11/28/2016 12:57 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	123,096	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,050,274	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	132,252	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	307,406	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)	10,613,028	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,540,000	0	0	0	12.00
13.00	Land improvements	267,675	0	0	0	13.00
14.00	Accumulated depreciation	-50,049	0	0	0	14.00
15.00	Buildings	21,305,100	0	0	0	15.00
16.00	Accumulated depreciation	-2,665,725	0	0	0	16.00
17.00	Leasehold improvements	1,570,548	0	0	0	17.00
18.00	Accumulated depreciation	-408,520	0	0	0	18.00
19.00	Fixed equipment	440,615	0	0	0	19.00
20.00	Accumulated depreciation	-94,266	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	2,157,239	0	0	0	23.00
24.00	Accumulated depreciation	-1,067,594	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,995,023	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	874,415	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	874,415	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,482,466	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,444,185	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,444,185	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,639,245	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,639,245	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,083,430	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	21,399,036				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	21,399,036	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,482,466	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144031

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

Worksheet G-1

Date/Time Prepared:
11/28/2016 12:57 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		20,276,863			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,992,766				2.00
3.00	Total (sum of line 1 and line 2)		26,269,629			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		26,269,629			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS TO AFFILIATES	5,870,593		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,870,593			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,399,036			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFERS TO AFFILIATES		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: 144031

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2016 12:57 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	81,674,990		81,674,990	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	81,674,990		81,674,990	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	81,674,990		81,674,990	17.00
18.00	Ancillary services	20,683,035		20,683,035	18.00
19.00	Outpatient services	0	54,607,537	54,607,537	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	RESEARCH	303,700	0	303,700	27.00
27.01	PHYSICIAN PRIVATE OFFICE	0	20,508,206	20,508,206	27.01
27.02	47	0	47,099	47,099	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	102,661,725	75,162,842	177,824,567	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		76,013,552		29.00
30.00	+	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)		76,013,552		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 144031	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/28/2016 12:57 pm
				1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			177,824,567 1.00
2.00	Less contractual allowances and discounts on patients' accounts			100,908,168 2.00
3.00	Net patient revenues (line 1 minus line 2)			76,916,399 3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			76,013,552 4.00
5.00	Net income from service to patients (line 3 minus line 4)			902,847 5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0 6.00
7.00	Income from investments			0 7.00
8.00	Revenues from telephone and other miscellaneous communication services			0 8.00
9.00	Revenue from television and radio service			0 9.00
10.00	Purchase discounts			0 10.00
11.00	Rebates and refunds of expenses			0 11.00
12.00	Parking lot receipts			0 12.00
13.00	Revenue from laundry and linen service			0 13.00
14.00	Revenue from meals sold to employees and guests		193,216	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		1,339	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	CAPI TATION REVENUE		0	24.00
24.01	SCHOOL EDUCATION REIMBURSEMENT		1,273,280	24.01
24.02	BUSINESS DEVELOPMENT		86,975	24.02
24.03	RESTRICTED FUNDS		371,016	24.03
24.04	CLINICAL RESEARCH		1,613,621	24.04
24.05	MISC REVENUE		95,641	24.05
24.06	IPPS REVENUE		166,213	24.06
24.07	ABMP PROFESSIONAL FEES		2,250	24.07
24.08	INTERNS AND RESIDENTS		380,650	24.08
24.09	INTAKE		188,440	24.09
24.10	ECT PUBLIC AID		37,200	24.10
24.11	PATIENT ACCOUNTS		27,789	24.11
24.12	SAFE PROGRAM		16,425	24.12
24.13	EDUCATION		0	24.13
24.14	OTHER FEES		-59,901	24.14
24.15	COMMUNITY ACTIVITY		0	24.15
24.16	ABPS REV		695,773	24.16
24.17	GAIN ON SALE M/E		0	24.17
25.00	Total other income (sum of lines 6-24)		5,089,927	25.00
26.00	Total (line 5 plus line 25)		5,992,774	26.00
27.00	RECONCILING AMOUNT		8	27.00
28.00	Total other expenses (sum of line 27 and subscripts)		8	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		5,992,766	29.00