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: 140100	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/22/2016 6:01 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/22/2016 Time: 6:01 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 MIDWESTERN REGIONAL MEDICAL CENTER (140100) 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-1,047	38,598	44,180	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	-1,047	38,598	44,180	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2016 5:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2501 EMMAUS AVENUE	PO Box:			1.00
2.00	City: ZION	State: IL	Zip Code: 60099	County: LAKE	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	MIDWESTERN REGIONAL MEDICAL CENTER	140100	29404	1	07/01/1967	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)	4		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	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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/22/2016 5:39 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	Y	40.00

		V	XVIII	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.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		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	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	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	
	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.				
64.00	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	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	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	
	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. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

			1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.		N	110.00

		1.00	2.00	3.00	
	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.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	3,673,774	0	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

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		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	14H130	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: CTCA	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 5900 BROKEN SOUND PARKWAY NW	PO Box:		142.00
143.00	City: BOCA RATON	State: FL	Zip Code: 33487	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	N	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	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140100	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/22/2016 5:39 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)	02/01/2015	05/01/2015	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/22/2016 5:39 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	10/28/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/27/2016	Y	09/27/2016	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 5:39 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	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.	CORY	RUTLEDGE	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-376-4500	CORY.RUTLEDGE@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 140100	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/22/2016 5:39 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.	PRINCIPAL		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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2016 5:39 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P 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	49	17,934	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)		49	17,934	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,784	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		73	26,718	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)		73				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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2016 5:39 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	601	22	7,031			1.00
2.00	HMO and other (see instructions)	121	0				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			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	601	22	7,031			7.00
8.00	INTENSIVE CARE UNIT	249	4	4,910			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	850	26	11,941	0.00	1,342.51	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	1,342.51	27.00
28.00	Observation Bed Days		2	1,231			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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/22/2016 5:39 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	164	10	2,078	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	164	10	2,078	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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2016 5:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	87,557,574	0	87,557,574	2,792,425.03	31.36	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		8,535,139	337,055	8,872,194	332,686.16	26.67	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,720,981	0	2,720,981	20,956.50	129.84	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		31,212,234	0	31,212,234	338,243.35	92.28	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		27,871,815	0	27,871,815			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,769,736	0	3,769,736			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	4,464,242	-3,349,882	1,114,360	25,607.25	43.52	26.00
27.00	Administrative & General	5.00	10,146,268	724,413	10,870,681	326,653.43	33.28	27.00
28.00	Administrative & General under contract (see inst.)		400,194	0	400,194	1,897.47	210.91	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,838,128	65,305	1,903,433	71,491.58	26.62	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,603,171	56,957	1,660,128	107,232.70	15.48	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,331,395	-2,030,146	301,249	18,680.52	16.13	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	119,395	2,117,217	2,236,612	136,662.08	16.37	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,642,620	58,359	1,700,979	40,129.30	42.39	38.00
39.00	Central Services and Supply	14.00	573,091	20,361	593,452	27,010.52	21.97	39.00
40.00	Pharmacy	15.00	3,325,484	118,147	3,443,631	90,443.96	38.07	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/22/2016 5:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	3,236,571	114,988	3,351,559	117,253.45	28.58	41.00
42.00	Social Service	17.00	844,649	30,009	874,658	32,442.43	26.96	42.00
43.00	Other General Service	18.00	7,048,226	250,408	7,298,634	207,965.25	35.10	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 11/22/2016 5:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		87,957,768	0	87,957,768	2,794,322.50	31.48	1.00
2.00	Excluded area salaries (see instructions)		8,535,139	337,055	8,872,194	332,686.16	26.67	2.00
3.00	Subtotal salaries (line 1 minus line 2)		79,422,629	-337,055	79,085,574	2,461,636.34	32.13	3.00
4.00	Subtotal other wages & related costs (see inst.)		33,933,215	0	33,933,215	359,199.85	94.47	4.00
5.00	Subtotal wage-related costs (see inst.)		27,871,815	0	27,871,815	0.00	35.24	5.00
6.00	Total (sum of lines 3 thru 5)		141,227,659	-337,055	140,890,604	2,820,836.19	49.95	6.00
7.00	Total overhead cost (see instructions)		37,573,434	-1,823,864	35,749,570	1,203,469.94	29.71	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 11/22/2016 5:39 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,220,499	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)	14,733,396	8.00
9.00	Prescription Drug Plan	3,071,929	9.00
10.00	Dental, Hearing and Vision Plan	1,409,226	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	153,681	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	676,094	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1,227,826	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	19,120	14.00
15.00	'Workers' Compensation Insurance	627,493	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	5,935,866	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	1,070,055	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	496,367	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	31,641,552	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 11/22/2016 5:39 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			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/22/2016 5:39 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.240380	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	882,044	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,830,857	6.00
7.00	Medicaid cost (line 1 times line 6)	680,481	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	20,034,836	20,034,836	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	4,815,974	4,815,974	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	4,815,974	4,815,974	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	18,799,071	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	100,458	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	18,698,613	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	4,494,773	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	9,310,747	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,310,747	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		15,926,858	15,926,858	-240,279	15,686,579	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		10,322,164	10,322,164	0	10,322,164	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,464,242	22,782,642	27,246,884	-2,647,034	24,599,850	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,146,268	308,864,397	319,010,665	-392,629	318,618,036	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,838,128	6,217,187	8,055,315	65,305	8,120,620	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	180,533	180,533	0	180,533	8.00
9.00	00900	HOUSEKEEPING	1,603,171	1,078,490	2,681,661	56,957	2,738,618	9.00
10.00	01000	DIETARY	2,331,395	3,713,838	6,045,233	-5,280,567	764,666	10.00
11.00	01100	CAFETERIA	119,395	285,716	405,111	5,367,638	5,772,749	11.00
13.00	01300	NURSING ADMINISTRATION	1,642,620	619,030	2,261,650	58,359	2,320,009	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	573,091	586,298	1,159,389	20,361	1,179,750	14.00
15.00	01500	PHARMACY	3,325,484	641,425	3,966,909	118,147	4,085,056	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,236,571	633,878	3,870,449	114,988	3,985,437	16.00
17.00	01700	SOCIAL SERVICE	844,649	453,380	1,298,029	30,009	1,328,038	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	7,048,226	1,650,085	8,698,311	250,408	8,948,719	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,515,029	1,803,464	10,318,493	302,521	10,621,014	30.00
31.00	03100	INTENSIVE CARE UNIT	4,358,129	980,727	5,338,856	154,835	5,493,691	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,039,211	2,137,794	7,177,005	179,032	7,356,037	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,520,309	1,785,790	5,306,099	125,069	5,431,168	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,288,836	3,595,651	5,884,487	81,317	5,965,804	55.00
56.00	05600	RADIOISOTOPE	419,252	98,817	518,069	14,895	532,964	56.00
57.00	05700	CT SCAN	564,637	382,150	946,787	20,060	966,847	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	471,074	495,687	966,761	16,736	983,497	58.00
60.00	06000	LABORATORY	3,158,241	6,067,975	9,226,216	112,205	9,338,421	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,103,819	1,103,819	0	1,103,819	63.00
64.00	06400	INTRAVENOUS THERAPY	2,183,688	302,280	2,485,968	77,582	2,563,550	64.00
65.00	06500	RESPIRATORY THERAPY	973,228	379,528	1,352,756	34,577	1,387,333	65.00
66.00	06600	PHYSICAL THERAPY	1,464,105	291,476	1,755,581	52,016	1,807,597	66.00
69.00	06900	ELECTROCARDIOLOGY	420,636	113,856	534,492	14,944	549,436	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,350,986	18,350,986	0	18,350,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	102,953,693	102,953,693	0	102,953,693	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	899,109	152,687	1,051,796	31,943	1,083,739	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,572,572	1,168,319	7,740,891	233,509	7,974,400	90.00
91.00	09100	EMERGENCY	1,001,139	157,230	1,158,369	35,568	1,193,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		554,221	554,221	-338,712	215,509	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	79,022,435	516,832,071	595,854,506	-1,330,240	594,524,266	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,278	47,278	0	47,278	190.00
191.00	19100	RESEARCH	636,750	255,681	892,431	22,622	915,053	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	7,898,389	33,450,910	41,349,299	1,307,618	42,656,917	194.00
200.00		TOTAL (SUM OF LINES 118-199)	87,557,574	550,585,940	638,143,514	0	638,143,514	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/22/2016 5:39 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	-4,735,038	10,951,541		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,944,244	13,266,408		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-75,372	24,524,478		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-246,797,993	71,820,043		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	8,120,620		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	180,533		8.00
9.00	00900	HOUSEKEEPING	-41,777	2,696,841		9.00
10.00	01000	DIETARY	-197	764,469		10.00
11.00	01100	CAFETERIA	-3,901,871	1,870,878		11.00
13.00	01300	NURSING ADMINISTRATION	-84	2,319,925		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,179,750		14.00
15.00	01500	PHARMACY	-30	4,085,026		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,743	3,979,694		16.00
17.00	01700	SOCIAL SERVICE	-112,928	1,215,110		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	-107,939	8,840,780		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-30,369	10,590,645		30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,493,691		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,356,037		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,462	5,429,706		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-16,229	5,949,575		55.00
56.00	05600	RADIOISOTOPE	0	532,964		56.00
57.00	05700	CT SCAN	0	966,847		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	983,497		58.00
60.00	06000	LABORATORY	0	9,338,421		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	-1,100	1,102,719		63.00
64.00	06400	INTRAVENOUS THERAPY	-900	2,562,650		64.00
65.00	06500	RESPIRATORY THERAPY	-280	1,387,053		65.00
66.00	06600	PHYSICAL THERAPY	0	1,807,597		66.00
69.00	06900	ELECTROCARDIOLOGY	0	549,436		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,350,986		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	102,953,693		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	-19	1,083,720		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-47	7,974,353		90.00
91.00	09100	EMERGENCY	0	1,193,937		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-215,509	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-253,100,643	341,423,623		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47,278		190.00
191.00	19100	RESEARCH	0	915,053		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	42,656,917		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-253,100,643	385,042,871		200.00

RECLASSIFICATIONS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/22/2016 5:39 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA				
1.00	CAFETERIA	11.00	2,112,975	3,250,421	1.00
	0		2,112,975	3,250,421	
	B - EMPLOYEE BONUS				
1.00	ADMINISTRATIVE & GENERAL	5.00	737,942	0	1.00
2.00	OPERATION OF PLANT	7.00	65,305	0	2.00
3.00	HOUSEKEEPING	9.00	56,957	0	3.00
4.00	DIETARY	10.00	82,829	0	4.00
5.00	CAFETERIA	11.00	4,242	0	5.00
6.00	NURSING ADMINISTRATION	13.00	58,359	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	20,361	0	7.00
8.00	PHARMACY	15.00	118,147	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	114,988	0	9.00
10.00	SOCIAL SERVICE	17.00	30,009	0	10.00
11.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	250,408	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	302,521	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	154,835	0	13.00
14.00	OPERATING ROOM	50.00	179,032	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	125,069	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	81,317	0	16.00
17.00	RADIOISOTOPE	56.00	14,895	0	17.00
18.00	CT SCAN	57.00	20,060	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	16,736	0	19.00
20.00	LABORATORY	60.00	112,205	0	20.00
21.00	INTRAVENOUS THERAPY	64.00	77,582	0	21.00
22.00	RESPIRATORY THERAPY	65.00	34,577	0	22.00
23.00	PHYSICAL THERAPY	66.00	52,016	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	14,944	0	24.00
25.00	HOSPITAL NUTRITION	76.01	31,943	0	25.00
27.00	CLINIC	90.00	233,509	0	27.00
28.00	EMERGENCY	91.00	35,568	0	28.00
30.00	RESEARCH	191.00	22,622	0	30.00
31.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	300,904	0	31.00
	0		3,349,882	0	
	C - PROPERTY TAX				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	1,054,069	1.00
	0		0	1,054,069	
	D - TRAVEL/SCHEDULING				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	82,542	10,276	1.00
	0		82,542	10,276	
	E - GUEST SERVICES				
1.00		0.00	0	0	1.00
	0		0	0	
	F - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	338,712	1.00
	0		0	338,712	
	G - INSURANCE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	483,080	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	702,848	2.00
	0		0	1,185,928	
	H - TRANSPORTATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	69,013	79,162	1.00
	0		69,013	79,162	
	I - GUEST ACCOMODATIONS DEPRECIATION				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	8,002	1.00
	TOTALS		0	8,002	
500.00	Grand Total: Increases		5,614,412	5,926,570	500.00

RECLASSIFICATIONS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/22/2016 5:39 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RECLASS CAFETERIA					
1.00	DIETARY	10.00	2,112,975	3,250,421	0	1.00
	0		2,112,975	3,250,421		
	B - EMPLOYEE BONUS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	3,349,882	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
	0		3,349,882	0		
	C - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,054,069	13	1.00
	0		0	1,054,069		
	D - TRAVEL/SCHEDULING					
1.00	ADMINISTRATIVE & GENERAL	5.00	82,542	10,276	0	1.00
	0		82,542	10,276		
	E - GUEST SERVICES					
1.00		0.00	0	0	0	1.00
	0		0	0		
	F - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	338,712	11	1.00
	0		0	338,712		
	G - INSURANCE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,185,928	12	1.00
2.00		0.00	0	0	0	2.00
	0		0	1,185,928		
	H - TRANSPORTATION					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	69,013	79,162	0	1.00
	0		69,013	79,162		
	I - GUEST ACCOMODATIONS DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,002	9	1.00
	TOTALS		0	8,002		
500.00	Grand Total: Decreases		5,614,412	5,926,570		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/22/2016 5:39 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	0	0	0	0	0	1.00
2.00	Land Improvements	1,126,605	0	0	0	0	2.00
3.00	Buildings and Fixtures	99,286,115	23,457,668	0	23,457,668	9,876,164	3.00
4.00	Building Improvements	63,798,228	10,045,307	0	10,045,307	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	78,960,253	7,089,709	0	7,089,709	977,857	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	243,171,201	40,592,684	0	40,592,684	10,854,021	8.00
9.00	Reconciling Items	77,247,042	24,320,247	0	24,320,247	9,876,164	9.00
10.00	Total (line 8 minus line 9)	165,924,159	16,272,437	0	16,272,437	977,857	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	1,126,605	0	2.00
3.00	Buildings and Fixtures	112,867,619	0	3.00
4.00	Building Improvements	73,843,535	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	85,072,105	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	272,909,864	0	8.00
9.00	Reconciling Items	91,691,125	0	9.00
10.00	Total (line 8 minus line 9)	181,218,739	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 11/22/2016 5:39 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,230,363	0	0	195,600	4,730,755	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,189,623	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,419,986	0	0	195,600	4,730,755	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	5,770,140	15,926,858	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,132,541	10,322,164	2.00
3.00	Total (sum of lines 1-2)	8,902,681	26,249,022	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/22/2016 5:39 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	187,837,759	31,636,645	156,201,114	0.778464	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	85,072,105	40,620,180	44,451,925	0.221536	0	2.00
3.00	Total (sum of lines 1-2)	272,909,864	72,256,825	200,653,039	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	6,719,366	-5,464,973	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	11,090,091	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,809,457	-5,464,973	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	-395,873	646,195	3,676,686	5,770,140	10,951,541	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,176,317	13,266,408	2.00
3.00	Total (sum of lines 1-2)	-395,873	646,195	3,676,686	7,946,457	24,217,949	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/22/2016 5:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-734,585	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-237,143,899			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,661,618	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-232,183	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-811,828	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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	OTHER REVENUE	B	-900	INTRAVENOUS THERAPY	64.00	0	33.00
33.01	OTHER REVENUE	B	-4,082,834	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/22/2016 5:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	OTHER REVENUE	B	-1,100	BLOOD STORING, PROCESSING & TRANS.	63.00	0	33.02
33.03	OTHER REVENUE	B	383	SOCIAL SERVICE	17.00	0	33.03
33.04	OTHER REVENUE	B	-5,743	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05			0		0.00	0	33.05
34.00	NON-ALLOWABLE EXPENSE	A	-113,311	SOCIAL SERVICE	17.00	0	34.00
34.01			0		0.00	0	34.01
34.02	NON-ALLOWABLE EXPENSE	A	-30,369	ADULTS & PEDIATRICS	30.00	0	34.02
34.03			0		0.00	0	34.03
34.04			0		0.00	0	34.04
34.05	NON-ALLOWABLE EXPENSE	A	-1,462	RADIOLOGY-DIAGNOSTIC	54.00	0	34.05
34.06			0		0.00	0	34.06
34.07			0		0.00	0	34.07
34.08	NON-ALLOWABLE EXPENSE	A	-107,939	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	34.08
34.09	NON-ALLOWABLE EXPENSE	A	-197	DIETARY	10.00	0	34.09
34.10			0		0.00	0	34.10
34.11	NON-ALLOWABLE EXPENSE	A	-5,874,322	ADMINISTRATIVE & GENERAL	5.00	0	34.11
34.12	NON-ALLOWABLE EXPENSE	A	-17	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.12
34.13			0		0.00	0	34.13
34.14	NON-ALLOWABLE EXPENSE	A	-41,777	HOUSEKEEPING	9.00	0	34.14
34.15	NON-ALLOWABLE EXPENSE	A	-16,229	RADIOLOGY-THERAPEUTIC	55.00	0	34.15
34.16	NON-ALLOWABLE EXPENSE	A	-280	RESPIRATORY THERAPY	65.00	0	34.16
34.17	CAFETERIA	A	-2,240,253	CAFETERIA	11.00	0	34.17
34.18	NON-ALLOWABLE EXPENSE	A	-47	CLINIC	90.00	0	34.18
34.19	NON-ALLOWABLE EXPENSE	A	-19	HOSPITAL NUTRITION	76.01	0	34.19
34.20	NON-ALLOWABLE EXPENSE	A	-84	NURSING ADMINISTRATION	13.00	0	34.20
34.21	NON-ALLOWABLE EXPENSE	A	-30	PHARMACY	15.00	0	34.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-253,100,643				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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2016 5:39 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	0.00		MANAGEMENT FEES	0	0	1.00
2.00	0.00		RISING TIDE IP REIMBURSEMENT	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	115,814	3,174,000	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	GUARANTEE FEES	0	94,365	4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	5,040,535	5,040,535	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES -	0	956,224	4.03
4.04	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	458,596	4.04
4.05	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL L	338,712	0	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	268,156	5,733,129	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES - NEW	0	36,974,106	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE	0	242,557,643	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE	450,595	483,080	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	INSURANCE	627,493	702,848	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	2,095,245	5,232,128	4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1,729,188	0	4.12
4.13	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	4,712,296	0	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	49,097,543	0	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	BROKERAGE FEES	0	117,197	4.15
5.00	0		0	64,475,577	301,619,476	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		
	Symbol (1)	Name	Percentage of Ownership	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	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
10.07			0.00		0.00	10.07
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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/22/2016 5:39 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	0	0		1.00
2.00	0	0		2.00
3.00	-3,058,186	0		3.00
4.00	-94,365	0		4.00
4.01	-95,625	0		4.01
4.02	0	14		4.02
4.03	-956,224	14		4.03
4.04	-458,596	0		4.04
4.05	338,712	0		4.05
4.06	-5,464,973	10		4.06
4.07	-36,974,106	0		4.07
4.08	-242,557,643	0		4.08
4.09	-32,485	12		4.09
4.10	-75,355	0		4.10
4.11	-3,136,883	0		4.11
4.12	1,729,188	9		4.12
4.13	4,712,296	9		4.13
4.14	49,097,543	0		4.14
4.15	-117,197	0		4.15
5.00	-237,143,899			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	PROPERTY		6.00
7.00	MANAGEMENT		7.00
8.00	CONSULTING		8.00
9.00	CORPORATE JET		9.00
10.00	SECURITIES FINA		10.00
10.01	RENTS BLDG SHAR		10.01
10.02	PROPERTY COMP		10.02
10.03	PROPERTY COMP		10.03
10.04	FINANCIAL		10.04
10.05	INSURANCE		10.05
10.06	CAPITAL MANAGEM		10.06
10.07			10.07
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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/22/2016 5:39 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	0.00		0	0	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			0	0	0		0	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	0.00		0	0	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			0	0	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	0.00		0	0	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	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	10,951,541	10,951,541				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	13,266,408		13,266,408			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	24,524,478	266,747	5,408	24,796,633		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	71,820,043	391,789	4,762,000	3,118,275	80,092,107	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	8,120,620	1,985,210	391,369	546,009	11,043,208	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	180,533	0	0	0	180,533	8.00
9.00	00900	HOUSEKEEPING	2,696,841	186,440	15,209	476,216	3,374,706	9.00
10.00	01000	DIETARY	764,469	314,167	108,562	86,415	1,273,613	10.00
11.00	01100	CAFETERIA	1,870,878	425,633	3,497	641,583	2,941,591	11.00
13.00	01300	NURSING ADMINISTRATION	2,319,925	24,721	2,987	487,934	2,835,567	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,179,750	137,218	856,787	170,235	2,343,990	14.00
15.00	01500	PHARMACY	4,085,026	129,345	241,788	987,823	5,443,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,979,694	144,244	0	961,411	5,085,349	16.00
17.00	01700	SOCIAL SERVICE	1,215,110	55,034	0	250,900	1,521,044	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	8,840,780	254,644	251	2,093,650	11,189,325	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,590,645	2,048,633	89,330	2,529,358	15,257,966	30.00
31.00	03100	INTENSIVE CARE UNIT	5,493,691	526,174	278,683	1,294,566	7,593,114	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,356,037	711,878	1,607,911	1,496,879	11,172,705	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,429,706	420,557	1,501,377	1,045,695	8,397,335	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,949,575	475,701	981,025	679,890	8,086,191	55.00
56.00	05600	RADIOISOTOPE	532,964	14,715	154,644	124,537	826,860	56.00
57.00	05700	CT SCAN	966,847	24,353	358,080	167,723	1,517,003	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	983,497	54,666	884,692	139,931	2,062,786	58.00
60.00	06000	LABORATORY	9,338,421	266,637	307,613	938,144	10,850,815	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,102,719	10,742	122,064	0	1,235,525	63.00
64.00	06400	INTRAVENOUS THERAPY	2,562,650	319,979	9,821	648,657	3,541,107	64.00
65.00	06500	RESPIRATORY THERAPY	1,387,053	37,560	33,528	289,094	1,747,235	65.00
66.00	06600	PHYSICAL THERAPY	1,807,597	92,668	10,583	434,907	2,345,755	66.00
69.00	06900	ELECTROCARDIOLOGY	549,436	9,418	104,975	124,948	788,777	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,350,986	0	0	0	18,350,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,953,693	0	0	0	102,953,693	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,083,720	27,113	1,300	267,077	1,379,210	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,974,353	1,386,343	104,819	1,952,358	11,417,873	90.00
91.00	09100	EMERGENCY	1,193,937	84,612	22,051	297,385	1,597,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	341,423,623	10,826,941	12,960,354	22,251,600	338,447,936	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,278	38,774	0	0	86,052	190.00
191.00	19100	RESEARCH	915,053	0	890	189,144	1,105,087	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	42,656,917	85,826	305,164	2,355,889	45,403,796	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	385,042,871	10,951,541	13,266,408	24,796,633	385,042,871	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 5:39 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	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	80,092,107					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,900,377	0	13,943,585			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,415	0	0	227,948		8.00
9.00	00900	HOUSEKEEPING	886,329	0	269,101	0	4,530,136	9.00
10.00	01000	DIETARY	334,500	0	453,457	0	175,244	10.00
11.00	01100	CAFETERIA	772,577	0	614,344	0	237,421	11.00
13.00	01300	NURSING ADMINISTRATION	744,730	0	35,682	0	13,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	615,623	0	198,055	0	76,541	14.00
15.00	01500	PHARMACY	1,429,802	0	186,693	0	72,150	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,335,611	0	208,197	0	80,460	16.00
17.00	01700	SOCIAL SERVICE	399,485	0	79,435	0	30,698	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	2,938,753	0	367,544	1,396	142,042	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,007,337	0	2,956,920	69,430	1,142,737	30.00
31.00	03100	INTENSIVE CARE UNIT	1,994,248	0	759,461	7,741	293,503	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,934,388	0	1,027,499	33,478	397,089	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,205,468	0	607,016	46,196	234,589	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,123,749	0	686,610	20,718	265,349	55.00
56.00	05600	RADIOISOTOPE	217,166	0	21,239	0	8,208	56.00
57.00	05700	CT SCAN	398,424	0	35,151	0	13,584	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	541,768	0	78,904	0	30,493	58.00
60.00	06000	LABORATORY	2,849,847	0	384,854	0	148,732	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	324,497	0	15,505	0	5,992	63.00
64.00	06400	INTRAVENOUS THERAPY	930,033	0	461,846	27,123	178,486	64.00
65.00	06500	RESPIRATORY THERAPY	458,892	0	54,213	0	20,951	65.00
66.00	06600	PHYSICAL THERAPY	616,087	0	133,754	6,444	51,691	66.00
69.00	06900	ELECTROCARDIOLOGY	207,164	0	13,593	1,971	5,253	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,819,685	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,039,798	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	362,234	0	39,133	0	15,124	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,998,779	0	2,000,998	11,239	773,310	90.00
91.00	09100	EMERGENCY	419,693	0	122,125	2,212	47,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,854,459	0	11,811,329	227,948	4,460,634	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	22,601	0	55,965	0	21,628	190.00
191.00	19100	RESEARCH	290,239	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	11,924,808	0	2,076,291	0	47,874	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	80,092,107	0	13,943,585	227,948	4,530,136	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	2,236,814					10.00
11.00	01100	CAFETERIA	0	4,565,933				11.00
13.00	01300	NURSING ADMINISTRATION	0	86,998	3,716,767			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,559	0	3,292,768		14.00
15.00	01500	PHARMACY	0	196,079	0	0	7,328,706	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	254,200	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	70,333	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	450,859	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,537,062	542,308	1,470,656	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	68,002	277,854	753,615	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	326,330	883,636	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	231,948	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	142,355	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	19,356	0	0	0	56.00
57.00	05700	CT SCAN	0	33,332	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	24,663	0	0	0	58.00
60.00	06000	LABORATORY	0	241,977	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	616,359	133,414	361,855	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	60,755	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	100,175	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	23,637	64,111	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,292,768	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,328,706	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	67,877	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	437,839	9,749	0	0	90.00
91.00	09100	EMERGENCY	15,391	63,838	173,145	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,236,814	3,844,686	3,716,767	3,292,768	7,328,706	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	33,837	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	687,410	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,236,814	4,565,933	3,716,767	3,292,768	7,328,706	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,963,817					16.00
17.00	01700	SOCIAL SERVICE	0	2,100,995				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	15,089,919			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	124,934	37,688	270,715	27,417,753	0	30.00
31.00	03100	INTENSIVE CARE UNIT	73,084	22,047	158,363	12,001,032	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	510,897	154,118	1,107,042	18,547,182	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	304,393	91,824	659,578	12,778,347	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	385,915	116,415	836,223	12,663,525	0	55.00
56.00	05600	RADIOISOTOPE	31,403	9,473	68,046	1,201,751	0	56.00
57.00	05700	CT SCAN	462,406	139,490	1,001,970	3,601,360	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	121,038	36,512	262,273	3,158,437	0	58.00
60.00	06000	LABORATORY	470,146	141,825	1,018,740	16,106,936	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	35,563	10,728	77,060	1,704,870	0	63.00
64.00	06400	INTRAVENOUS THERAPY	195,893	59,093	424,472	6,929,681	0	64.00
65.00	06500	RESPIRATORY THERAPY	22,154	6,683	48,004	2,418,887	0	65.00
66.00	06600	PHYSICAL THERAPY	27,268	8,226	59,086	3,348,486	0	66.00
69.00	06900	ELECTROCARDIOLOGY	45,436	13,706	98,453	1,262,101	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	217,386	65,577	471,045	27,217,447	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,869,956	1,167,697	8,385,954	150,745,804	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	5,341	1,611	11,573	1,882,103	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	54,712	16,505	118,554	17,839,558	0	90.00
91.00	09100	EMERGENCY	5,892	1,777	12,768	2,462,023	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,963,817	2,100,995	15,089,919	323,287,283	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	186,246	0	190.00
191.00	19100	RESEARCH	0	0	0	1,429,163	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	60,140,179	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,963,817	2,100,995	15,089,919	385,042,871	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	27,417,753		30.00
31.00	03100	INTENSIVE CARE UNIT	12,001,032		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	18,547,182		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,778,347		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,663,525		55.00
56.00	05600	RADIOISOTOPE	1,201,751		56.00
57.00	05700	CT SCAN	3,601,360		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,158,437		58.00
60.00	06000	LABORATORY	16,106,936		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,704,870		63.00
64.00	06400	INTRAVENOUS THERAPY	6,929,681		64.00
65.00	06500	RESPIRATORY THERAPY	2,418,887		65.00
66.00	06600	PHYSICAL THERAPY	3,348,486		66.00
69.00	06900	ELECTROCARDIOLOGY	1,262,101		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,217,447		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,745,804		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	HOSPITAL NUTRITION	1,882,103		76.01
76.02	03952	PAIN MANAGEMENT	0		76.02
76.03	03954	INFUSION CENTER	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	17,839,558		90.00
91.00	09100	EMERGENCY	2,462,023		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	323,287,283		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	186,246		190.00
191.00	19100	RESEARCH	1,429,163		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	60,140,179		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	385,042,871		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		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	266,747	5,408	272,155	272,155	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	391,789	4,762,000	5,153,789	34,250	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	1,985,210	391,369	2,376,579	5,992	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	186,440	15,209	201,649	5,226	9.00
10.00	01000	DIETARY	0	314,167	108,562	422,729	948	10.00
11.00	01100	CAFETERIA	0	425,633	3,497	429,130	7,041	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,721	2,987	27,708	5,355	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	137,218	856,787	994,005	1,868	14.00
15.00	01500	PHARMACY	0	129,345	241,788	371,133	10,841	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	144,244	0	144,244	10,551	16.00
17.00	01700	SOCIAL SERVICE	0	55,034	0	55,034	2,753	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	254,644	251	254,895	22,976	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,048,633	89,330	2,137,963	27,758	30.00
31.00	03100	INTENSIVE CARE UNIT	0	526,174	278,683	804,857	14,207	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	711,878	1,607,911	2,319,789	16,427	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	420,557	1,501,377	1,921,934	11,476	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	475,701	981,025	1,456,726	7,461	55.00
56.00	05600	RADIOISOTOPE	0	14,715	154,644	169,359	1,367	56.00
57.00	05700	CT SCAN	0	24,353	358,080	382,433	1,841	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	54,666	884,692	939,358	1,536	58.00
60.00	06000	LABORATORY	0	266,637	307,613	574,250	10,295	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	10,742	122,064	132,806	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	319,979	9,821	329,800	7,118	64.00
65.00	06500	RESPIRATORY THERAPY	0	37,560	33,528	71,088	3,173	65.00
66.00	06600	PHYSICAL THERAPY	0	92,668	10,583	103,251	4,773	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,418	104,975	114,393	1,371	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	27,113	1,300	28,413	2,931	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,386,343	104,819	1,491,162	21,426	90.00
91.00	09100	EMERGENCY	0	84,612	22,051	106,663	3,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	10,826,941	12,960,354	23,787,295	244,225	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,774	0	38,774	0	190.00
191.00	19100	RESEARCH	0	0	890	890	2,076	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	85,826	305,164	390,990	25,854	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	10,951,541	13,266,408	24,217,949	272,155	202.00

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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	5,188,039					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	187,878	0	2,570,449			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,071	0	0	3,071		8.00
9.00	00900	HOUSEKEEPING	57,414	0	49,608	0	313,897	9.00
10.00	01000	DIETARY	21,668	0	83,593	0	12,143	10.00
11.00	01100	CAFETERIA	50,045	0	113,252	0	16,451	11.00
13.00	01300	NURSING ADMINISTRATION	48,242	0	6,578	0	955	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,878	0	36,511	0	5,304	14.00
15.00	01500	PHARMACY	92,618	0	34,416	0	4,999	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	86,517	0	38,380	0	5,575	16.00
17.00	01700	SOCIAL SERVICE	25,878	0	14,643	0	2,127	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	190,364	0	67,755	19	9,842	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	259,584	0	545,098	936	79,182	30.00
31.00	03100	INTENSIVE CARE UNIT	129,182	0	140,004	104	20,337	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	190,081	0	189,416	451	27,515	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142,864	0	111,901	622	16,255	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	137,570	0	126,574	279	18,386	55.00
56.00	05600	RADIOISOTOPE	14,067	0	3,915	0	569	56.00
57.00	05700	CT SCAN	25,809	0	6,480	0	941	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35,094	0	14,546	0	2,113	58.00
60.00	06000	LABORATORY	184,605	0	70,946	0	10,306	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21,020	0	2,858	0	415	63.00
64.00	06400	INTRAVENOUS THERAPY	60,245	0	85,140	365	12,367	64.00
65.00	06500	RESPIRATORY THERAPY	29,726	0	9,994	0	1,452	65.00
66.00	06600	PHYSICAL THERAPY	39,908	0	24,657	87	3,582	66.00
69.00	06900	ELECTROCARDIOLOGY	13,419	0	2,506	27	364	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	312,205	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,751,464	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	23,464	0	7,214	0	1,048	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	194,252	0	368,877	151	53,583	90.00
91.00	09100	EMERGENCY	27,187	0	22,513	30	3,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,395,319	0	2,177,375	3,071	309,081	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,464	0	10,317	0	1,499	190.00
191.00	19100	RESEARCH	18,801	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	772,455	0	382,757	0	3,317	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,188,039	0	2,570,449	3,071	313,897	202.00

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		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	541,081					10.00
11.00	01100	CAFETERIA	0	615,919				11.00
13.00	01300	NURSING ADMINISTRATION	0	11,736	100,574			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,899	0	1,085,465		14.00
15.00	01500	PHARMACY	0	26,450	0	0	540,457	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,290	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,488	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	60,819	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	371,812	73,154	39,795	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,450	37,481	20,392	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	44,020	23,911	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,289	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	19,203	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	2,611	0	0	0	56.00
57.00	05700	CT SCAN	0	4,496	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,327	0	0	0	58.00
60.00	06000	LABORATORY	0	32,641	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	149,096	17,997	9,792	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,196	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,513	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,189	1,735	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,085,465	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	540,457	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	9,156	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	59,062	264	0	0	90.00
91.00	09100	EMERGENCY	3,723	8,611	4,685	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	541,081	518,628	100,574	1,085,465	540,457	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	4,564	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	92,727	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	541,081	615,919	100,574	1,085,465	540,457	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	319,557					16.00
17.00	01700	SOCIAL SERVICE	0	109,923				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	606,670			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,742	1,978	10,882	3,553,884	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,359	1,157	6,366	1,193,896	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,483	8,091	44,499	2,887,683	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,991	4,820	26,512	2,281,664	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	17,738	6,111	33,613	1,823,661	0	55.00
56.00	05600	RADIOISOTOPE	1,443	497	2,735	196,563	0	56.00
57.00	05700	CT SCAN	21,254	7,323	40,275	490,852	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,563	1,917	10,542	1,013,996	0	58.00
60.00	06000	LABORATORY	21,610	7,445	40,949	953,047	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,635	563	3,098	162,395	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9,004	3,102	17,062	701,088	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,018	351	1,930	126,928	0	65.00
66.00	06600	PHYSICAL THERAPY	1,253	432	2,375	193,831	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,088	720	3,957	143,769	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,992	3,443	18,934	1,430,039	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,353	60,929	337,198	2,867,401	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	245	85	465	73,021	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,515	866	4,765	2,196,923	0	90.00
91.00	09100	EMERGENCY	271	93	513	180,823	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	319,557	109,923	606,670	22,471,464	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	52,054	0	190.00
191.00	19100	RESEARCH	0	0	0	26,331	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,668,100	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	319,557	109,923	606,670	24,217,949	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,553,884		30.00
31.00	03100	INTENSIVE CARE UNIT	1,193,896		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,887,683		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,281,664		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,823,661		55.00
56.00	05600	RADIOISOTOPE	196,563		56.00
57.00	05700	CT SCAN	490,852		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,013,996		58.00
60.00	06000	LABORATORY	953,047		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	162,395		63.00
64.00	06400	INTRAVENOUS THERAPY	701,088		64.00
65.00	06500	RESPIRATORY THERAPY	126,928		65.00
66.00	06600	PHYSICAL THERAPY	193,831		66.00
69.00	06900	ELECTROCARDIOLOGY	143,769		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,430,039		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,867,401		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	HOSPITAL NUTRITION	73,021		76.01
76.02	03952	PAIN MANAGEMENT	0		76.02
76.03	03954	INFUSION CENTER	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2,196,923		90.00
91.00	09100	EMERGENCY	180,823		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,471,464		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	52,054		190.00
191.00	19100	RESEARCH	26,331		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,668,100		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	24,217,949		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	297,696					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		14,201,620				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,251	5,789	86,443,214			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,650	5,097,702	10,870,681	-80,092,107	304,950,764	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	53,964	418,958	1,903,433	0	11,043,208	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	180,533	8.00
9.00	00900	HOUSEKEEPING	5,068	16,281	1,660,128	0	3,374,706	9.00
10.00	01000	DIETARY	8,540	116,215	301,250	0	1,273,613	10.00
11.00	01100	CAFETERIA	11,570	3,743	2,236,612	0	2,941,591	11.00
13.00	01300	NURSING ADMINISTRATION	672	3,198	1,700,979	0	2,835,567	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	917,186	593,452	0	2,343,990	14.00
15.00	01500	PHARMACY	3,516	258,833	3,443,631	0	5,443,982	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	0	3,351,559	0	5,085,349	16.00
17.00	01700	SOCIAL SERVICE	1,496	0	874,658	0	1,521,044	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	6,922	269	7,298,634	0	11,189,325	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	55,688	95,627	8,817,550	0	15,257,966	30.00
31.00	03100	INTENSIVE CARE UNIT	14,303	298,328	4,512,964	0	7,593,114	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,351	1,721,259	5,218,243	0	11,172,705	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,432	1,607,215	3,645,378	0	8,397,335	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	1,050,182	2,370,153	0	8,086,191	55.00
56.00	05600	RADIOISOTOPE	400	165,545	434,147	0	826,860	56.00
57.00	05700	CT SCAN	662	383,323	584,697	0	1,517,003	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	947,058	487,810	0	2,062,786	58.00
60.00	06000	LABORATORY	7,248	329,298	3,270,446	0	10,850,815	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	130,669	0	0	1,235,525	63.00
64.00	06400	INTRAVENOUS THERAPY	8,698	10,513	2,261,270	0	3,541,107	64.00
65.00	06500	RESPIRATORY THERAPY	1,021	35,891	1,007,805	0	1,747,235	65.00
66.00	06600	PHYSICAL THERAPY	2,519	11,329	1,516,121	0	2,345,755	66.00
69.00	06900	ELECTROCARDIOLOGY	256	112,375	435,580	0	788,777	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	18,350,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	102,953,693	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	1,392	931,052	0	1,379,210	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,685	112,208	6,806,081	0	11,417,873	90.00
91.00	09100	EMERGENCY	2,300	23,605	1,036,707	0	1,597,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	294,309	13,873,991	77,571,021	-80,092,107	258,355,829	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	0	0	0	86,052	190.00
191.00	19100	RESEARCH	0	953	659,372	0	1,105,087	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,333	326,676	8,212,821	0	45,403,796	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	10,951,541	13,266,408	24,796,633		80,092,107	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	36.787666	0.934148	0.286855		0.262639	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			272,155		5,188,039	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003148		0.017013	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 5:39 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	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	279,795					6.00
7.00	00700	OPERATION OF PLANT	53,964	262,601				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	630,294			8.00
9.00	00900	HOUSEKEEPING	5,068	5,068	0	220,763		9.00
10.00	01000	DIETARY	8,540	8,540	0	8,540	48,978	10.00
11.00	01100	CAFETERIA	11,570	11,570	0	11,570	0	11.00
13.00	01300	NURSING ADMINISTRATION	672	672	0	672	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	3,730	0	14.00
15.00	01500	PHARMACY	3,516	3,516	0	3,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	3,921	0	3,921	0	16.00
17.00	01700	SOCIAL SERVICE	1,496	1,496	0	1,496	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	6,922	6,922	3,859	6,922	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	55,688	55,688	191,978	55,688	33,656	30.00
31.00	03100	INTENSIVE CARE UNIT	14,303	14,303	21,404	14,303	1,489	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,351	19,351	92,569	19,351	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,432	11,432	127,736	11,432	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	12,931	57,288	12,931	0	55.00
56.00	05600	RADIOISOTOPE	400	400	0	400	0	56.00
57.00	05700	CT SCAN	662	662	0	662	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	1,486	0	1,486	0	58.00
60.00	06000	LABORATORY	7,248	7,248	0	7,248	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	292	0	292	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8,698	8,698	74,997	8,698	13,496	64.00
65.00	06500	RESPIRATORY THERAPY	1,021	1,021	0	1,021	0	65.00
66.00	06600	PHYSICAL THERAPY	2,519	2,519	17,818	2,519	0	66.00
69.00	06900	ELECTROCARDIOLOGY	256	256	5,451	256	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	737	0	737	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,685	37,685	31,078	37,685	0	90.00
91.00	09100	EMERGENCY	2,300	2,300	6,116	2,300	337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	276,408	222,444	630,294	217,376	48,978	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	1,054	0	1,054	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,333	39,103	0	2,333	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	13,943,585	227,948	4,530,136	2,236,814	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	53.097989	0.361653	20.520359	45.669770	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,570,449	3,071	313,897	541,081	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	9.788420	0.004872	1.421873	11.047429	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/22/2016 5:39 pm

		Cost Center Description	CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	2,106,098					11.00
13.00	01300	NURSING ADMINISTRATION	40,129	632,094				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,011	0	1,000			14.00
15.00	01500	PHARMACY	90,444	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	117,253	0	0	0	1,344,903,469	16.00
17.00	01700	SOCIAL SERVICE	32,442	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	207,965	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	250,147	250,108	0	0	24,127,906	30.00
31.00	03100	INTENSIVE CARE UNIT	128,164	128,164	0	0	14,114,330	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	150,524	150,276	0	0	98,666,808	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	106,989	0	0	0	58,785,891	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	65,663	0	0	0	74,529,660	55.00
56.00	05600	RADIOISOTOPE	8,928	0	0	0	6,064,686	56.00
57.00	05700	CT SCAN	15,375	0	0	0	89,302,141	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,376	0	0	0	23,375,458	58.00
60.00	06000	LABORATORY	111,615	0	0	0	90,796,772	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	6,868,113	63.00
64.00	06400	INTRAVENOUS THERAPY	61,539	61,539	0	0	37,831,740	64.00
65.00	06500	RESPIRATORY THERAPY	28,024	0	0	0	4,278,471	65.00
66.00	06600	PHYSICAL THERAPY	46,207	0	0	0	5,266,158	66.00
69.00	06900	ELECTROCARDIOLOGY	10,903	10,903	0	0	8,774,805	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,000	0	41,982,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	747,402,180	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	31,309	0	0	0	1,031,457	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	201,959	1,658	0	0	10,566,312	90.00
91.00	09100	EMERGENCY	29,446	29,446	0	0	1,137,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,773,412	632,094	1,000	1,000	1,344,903,469	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	15,608	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	317,078	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,565,933	3,716,767	3,292,768	7,328,706	6,963,817	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.167958	5.880086	3,292.768000	7,328.706000	0.005178	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	615,919	100,574	1,085,465	540,457	319,557	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.292446	0.159112	1,085.465000	540.457000	0.000238	205.00

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		Cost Center Description	SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE (SPECIFY) (GROSS CHARGES)		
			17.00	18.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,344,903,469			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	1,344,903,469		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	24,127,906	24,127,906		30.00
31.00	03100	INTENSIVE CARE UNIT	14,114,330	14,114,330		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	98,666,808	98,666,808		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,785,891	58,785,891		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	74,529,660	74,529,660		55.00
56.00	05600	RADIOISOTOPE	6,064,686	6,064,686		56.00
57.00	05700	CT SCAN	89,302,141	89,302,141		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	23,375,458	23,375,458		58.00
60.00	06000	LABORATORY	90,796,772	90,796,772		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,868,113	6,868,113		63.00
64.00	06400	INTRAVENOUS THERAPY	37,831,740	37,831,740		64.00
65.00	06500	RESPIRATORY THERAPY	4,278,471	4,278,471		65.00
66.00	06600	PHYSICAL THERAPY	5,266,158	5,266,158		66.00
69.00	06900	ELECTROCARDIOLOGY	8,774,805	8,774,805		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,982,629	41,982,629		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	747,402,180	747,402,180		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	1,031,457	1,031,457		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	10,566,312	10,566,312		90.00
91.00	09100	EMERGENCY	1,137,952	1,137,952		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,344,903,469	1,344,903,469		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,100,995	15,089,919		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001562	0.011220		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	109,923	606,670		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000082	0.000451		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 5:39 pm

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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	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,417,753		27,417,753	0	27,417,753	30.00
31.00	03100	INTENSIVE CARE UNIT	12,001,032		12,001,032	0	12,001,032	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,547,182		18,547,182	0	18,547,182	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,778,347		12,778,347	0	12,778,347	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,663,525		12,663,525	0	12,663,525	55.00
56.00	05600	RADIOISOTOPE	1,201,751		1,201,751	0	1,201,751	56.00
57.00	05700	CT SCAN	3,601,360		3,601,360	0	3,601,360	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,158,437		3,158,437	0	3,158,437	58.00
60.00	06000	LABORATORY	16,106,936		16,106,936	0	16,106,936	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,704,870		1,704,870	0	1,704,870	63.00
64.00	06400	INTRAVENOUS THERAPY	6,929,681		6,929,681	0	6,929,681	64.00
65.00	06500	RESPIRATORY THERAPY	2,418,887	0	2,418,887	0	2,418,887	65.00
66.00	06600	PHYSICAL THERAPY	3,348,486	0	3,348,486	0	3,348,486	66.00
69.00	06900	ELECTROCARDIOLOGY	1,262,101		1,262,101	0	1,262,101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,217,447		27,217,447	0	27,217,447	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,745,804		150,745,804	0	150,745,804	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,882,103		1,882,103	0	1,882,103	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	17,839,558		17,839,558	0	17,839,558	90.00
91.00	09100	EMERGENCY	2,462,023		2,462,023	0	2,462,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,085,123		4,085,123		4,085,123	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	327,372,406	0	327,372,406	0	327,372,406	200.00
201.00		Less Observation Beds	4,085,123		4,085,123		4,085,123	201.00
202.00		Total (see instructions)	323,287,283	0	323,287,283	0	323,287,283	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 5:39 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,529,514		21,529,514			30.00
31.00	03100	INTENSIVE CARE UNIT	14,114,330		14,114,330			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,219,606	48,447,202	98,666,808	0.187978	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,953,710	50,832,181	58,785,891	0.217371	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,187,709	71,341,951	74,529,660	0.169913	0.000000	55.00
56.00	05600	RADIOISOTOPE	258,786	5,805,900	6,064,686	0.198156	0.000000	56.00
57.00	05700	CT SCAN	5,760,388	83,541,753	89,302,141	0.040328	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,526,376	20,849,082	23,375,458	0.135118	0.000000	58.00
60.00	06000	LABORATORY	16,646,174	74,150,598	90,796,772	0.177395	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,587,863	3,280,250	6,868,113	0.248230	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	146,682	37,685,058	37,831,740	0.183171	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,890,784	2,387,687	4,278,471	0.565362	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,721,482	2,544,676	5,266,158	0.635850	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,537,441	7,237,364	8,774,805	0.143832	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,528,197	19,454,432	41,982,629	0.648303	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,509,383	673,892,797	747,402,180	0.201693	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	72,022	959,435	1,031,457	1.824703	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	907,078	9,659,234	10,566,312	1.688343	0.000000	90.00
91.00	09100	EMERGENCY	181,237	956,715	1,137,952	2.163556	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,051,715	1,546,677	2,598,392	1.572173	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	230,330,477	1,114,572,992	1,344,903,469			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	230,330,477	1,114,572,992	1,344,903,469			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 5:39 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.187978		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217371		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.169913		55.00
56.00	05600	RADIOISOTOPE	0.198156		56.00
57.00	05700	CT SCAN	0.040328		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.135118		58.00
60.00	06000	LABORATORY	0.177395		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.248230		63.00
64.00	06400	INTRAVENOUS THERAPY	0.183171		64.00
65.00	06500	RESPIRATORY THERAPY	0.565362		65.00
66.00	06600	PHYSICAL THERAPY	0.635850		66.00
69.00	06900	ELECTROCARDIOLOGY	0.143832		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.648303		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201693		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951	HOSPITAL NUTRITION	1.824703		76.01
76.02	03952	PAIN MANAGEMENT	0.000000		76.02
76.03	03954	INFUSION CENTER	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1.688343		90.00
91.00	09100	EMERGENCY	2.163556		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.572173		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 5:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,417,753		27,417,753	0	27,417,753	30.00
31.00	03100	INTENSIVE CARE UNIT	12,001,032		12,001,032	0	12,001,032	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,547,182		18,547,182	0	18,547,182	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,778,347		12,778,347	0	12,778,347	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,663,525		12,663,525	0	12,663,525	55.00
56.00	05600	RADIOISOTOPE	1,201,751		1,201,751	0	1,201,751	56.00
57.00	05700	CT SCAN	3,601,360		3,601,360	0	3,601,360	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,158,437		3,158,437	0	3,158,437	58.00
60.00	06000	LABORATORY	16,106,936		16,106,936	0	16,106,936	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,704,870		1,704,870	0	1,704,870	63.00
64.00	06400	INTRAVENOUS THERAPY	6,929,681		6,929,681	0	6,929,681	64.00
65.00	06500	RESPIRATORY THERAPY	2,418,887	0	2,418,887	0	2,418,887	65.00
66.00	06600	PHYSICAL THERAPY	3,348,486	0	3,348,486	0	3,348,486	66.00
69.00	06900	ELECTROCARDIOLOGY	1,262,101		1,262,101	0	1,262,101	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,217,447		27,217,447	0	27,217,447	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,745,804		150,745,804	0	150,745,804	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,882,103		1,882,103	0	1,882,103	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	17,839,558		17,839,558	0	17,839,558	90.00
91.00	09100	EMERGENCY	2,462,023		2,462,023	0	2,462,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,085,123		4,085,123		4,085,123	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	327,372,406	0	327,372,406	0	327,372,406	200.00
201.00		Less Observation Beds	4,085,123		4,085,123		4,085,123	201.00
202.00		Total (see instructions)	323,287,283	0	323,287,283	0	323,287,283	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 5:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,529,514		21,529,514			30.00
31.00	03100	INTENSIVE CARE UNIT	14,114,330		14,114,330			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	50,219,606	48,447,202	98,666,808	0.187978	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,953,710	50,832,181	58,785,891	0.217371	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,187,709	71,341,951	74,529,660	0.169913	0.000000	55.00
56.00	05600	RADIOISOTOPE	258,786	5,805,900	6,064,686	0.198156	0.000000	56.00
57.00	05700	CT SCAN	5,760,388	83,541,753	89,302,141	0.040328	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,526,376	20,849,082	23,375,458	0.135118	0.000000	58.00
60.00	06000	LABORATORY	16,646,174	74,150,598	90,796,772	0.177395	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,587,863	3,280,250	6,868,113	0.248230	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	146,682	37,685,058	37,831,740	0.183171	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,890,784	2,387,687	4,278,471	0.565362	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,721,482	2,544,676	5,266,158	0.635850	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,537,441	7,237,364	8,774,805	0.143832	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,528,197	19,454,432	41,982,629	0.648303	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,509,383	673,892,797	747,402,180	0.201693	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	72,022	959,435	1,031,457	1.824703	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	907,078	9,659,234	10,566,312	1.688343	0.000000	90.00
91.00	09100	EMERGENCY	181,237	956,715	1,137,952	2.163556	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,051,715	1,546,677	2,598,392	1.572173	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	230,330,477	1,114,572,992	1,344,903,469			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	230,330,477	1,114,572,992	1,344,903,469			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/22/2016 5:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951	HOSPITAL NUTRITION	0.000000		76.01
76.02	03952	PAIN MANAGEMENT	0.000000		76.02
76.03	03954	INFUSION CENTER	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,553,884	0	3,553,884	8,262	430.15	30.00
31.00	INTENSIVE CARE UNIT	1,193,896		1,193,896	4,910	243.16	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
200.00	Total (lines 30-199)	4,747,780		4,747,780	13,172		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	601	258,520		30.00
31.00	INTENSIVE CARE UNIT	249	60,547		31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
200.00	Total (lines 30-199)	850	319,067		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,887,683	98,666,808	0.029267	2,980,980	87,244	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,281,664	58,785,891	0.038813	624,512	24,239	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,823,661	74,529,660	0.024469	197,277	4,827	55.00
56.00	05600	RADIOISOTOPE	196,563	6,064,686	0.032411	18,057	585	56.00
57.00	05700	CT SCAN	490,852	89,302,141	0.005497	598,323	3,289	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,013,996	23,375,458	0.043379	206,353	8,951	58.00
60.00	06000	LABORATORY	953,047	90,796,772	0.010496	1,275,785	13,391	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	162,395	6,868,113	0.023645	172,852	4,087	63.00
64.00	06400	INTRAVENOUS THERAPY	701,088	37,831,740	0.018532	15,313	284	64.00
65.00	06500	RESPIRATORY THERAPY	126,928	4,278,471	0.029667	102,560	3,043	65.00
66.00	06600	PHYSICAL THERAPY	193,831	5,266,158	0.036807	212,305	7,814	66.00
69.00	06900	ELECTROCARDIOLOGY	143,769	8,774,805	0.016384	224,295	3,675	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,430,039	41,982,629	0.034063	1,409,197	48,001	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,867,401	747,402,180	0.003836	4,025,009	15,440	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	73,021	1,031,457	0.070794	6,051	428	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,196,923	10,566,312	0.207918	94,630	19,675	90.00
91.00	09100	EMERGENCY	180,823	1,137,952	0.158902	16,946	2,693	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	529,514	2,598,392	0.203785	99,593	20,296	92.00
200.00		Total (lines 50-199)	18,253,198	1,309,259,625		12,280,038	267,962	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,262	0.00	601	0		30.00
31.00	03100	INTENSIVE CARE UNIT	4,910	0.00	249	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0		34.00
200.00		Total (lines 30-199)	13,172		850	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	98,666,808	0.000000	0.000000	2,980,980	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,785,891	0.000000	0.000000	624,512	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	74,529,660	0.000000	0.000000	197,277	55.00
56.00	05600	RADIOISOTOPE	0	6,064,686	0.000000	0.000000	18,057	56.00
57.00	05700	CT SCAN	0	89,302,141	0.000000	0.000000	598,323	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	23,375,458	0.000000	0.000000	206,353	58.00
60.00	06000	LABORATORY	0	90,796,772	0.000000	0.000000	1,275,785	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	6,868,113	0.000000	0.000000	172,852	63.00
64.00	06400	INTRAVENOUS THERAPY	0	37,831,740	0.000000	0.000000	15,313	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,278,471	0.000000	0.000000	102,560	65.00
66.00	06600	PHYSICAL THERAPY	0	5,266,158	0.000000	0.000000	212,305	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,774,805	0.000000	0.000000	224,295	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,982,629	0.000000	0.000000	1,409,197	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	747,402,180	0.000000	0.000000	4,025,009	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	1,031,457	0.000000	0.000000	6,051	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0.000000	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,566,312	0.000000	0.000000	94,630	90.00
91.00	09100	EMERGENCY	0	1,137,952	0.000000	0.000000	16,946	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,598,392	0.000000	0.000000	99,593	92.00
200.00		Total (lines 50-199)	0	1,309,259,625			12,280,038	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,504,703	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,620,554	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	6,025,806	0		55.00
56.00	05600	RADIOISOTOPE	0	442,367	0		56.00
57.00	05700	CT SCAN	0	9,851,681	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,622,400	0		58.00
60.00	06000	LABORATORY	0	5,167,670	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	205,775	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,955,803	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	213,553	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	517,963	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	947,403	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55,168,854	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0	0		76.02
76.03	03954	INFUSION CENTER	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	871,729	0		90.00
91.00	09100	EMERGENCY	0	88,375	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	103,800	0		92.00
200.00		Total (lines 50-199)	0	92,308,436	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.187978	3,504,703	0	0	658,807	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217371	4,620,554	0	0	1,004,374	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.169913	6,025,806	0	0	1,023,863	55.00
56.00	05600	RADIOISOTOPE	0.198156	442,367	0	0	87,658	56.00
57.00	05700	CT SCAN	0.040328	9,851,681	0	0	397,299	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.135118	1,622,400	0	0	219,215	58.00
60.00	06000	LABORATORY	0.177395	5,167,670	105,341	0	916,719	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.248230	205,775	0	0	51,080	63.00
64.00	06400	INTRAVENOUS THERAPY	0.183171	2,955,803	0	0	541,417	64.00
65.00	06500	RESPIRATORY THERAPY	0.565362	213,553	0	0	120,735	65.00
66.00	06600	PHYSICAL THERAPY	0.635850	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.143832	517,963	0	0	74,500	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.648303	947,403	0	0	614,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201693	55,168,854	0	100,986	11,127,172	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1.824703	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.688343	871,729	0	0	1,471,778	90.00
91.00	09100	EMERGENCY	2.163556	88,375	0	0	191,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.572173	103,800	0	0	163,192	92.00
200.00		Subtotal (see instructions)		92,308,436	105,341	100,986	18,663,217	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		92,308,436	105,341	100,986	18,663,217	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	18,687	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,368	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	18,687	20,368	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	18,687	20,368	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,262	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,262	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,031	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)	601	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)	27,417,753	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)	27,417,753	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)	27,417,753	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)	3,318.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,994,443	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)	1,994,443	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	12,001,032	4,910	2,444.20	249	608,606	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	3,371,941	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,974,990	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)	319,067	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	267,962	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	587,029	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,387,961	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)	1,231	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,318.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,085,123	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/22/2016 5:39 pm

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,553,884	27,417,753	0.129620	4,085,123	529,514	90.00
91.00	Nursing School cost	0	27,417,753	0.000000	4,085,123	0	91.00
92.00	Allied health cost	0	27,417,753	0.000000	4,085,123	0	92.00
93.00	All other Medical Education	0	27,417,753	0.000000	4,085,123	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/22/2016 5:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,186,406		30.00
31.00	03100	INTENSIVE CARE UNIT		991,703		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.187978	2,980,980	560,359	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217371	624,512	135,751	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.169913	197,277	33,520	55.00
56.00	05600	RADIOISOTOPE	0.198156	18,057	3,578	56.00
57.00	05700	CT SCAN	0.040328	598,323	24,129	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.135118	206,353	27,882	58.00
60.00	06000	LABORATORY	0.177395	1,275,785	226,318	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.248230	172,852	42,907	63.00
64.00	06400	INTRAVENOUS THERAPY	0.183171	15,313	2,805	64.00
65.00	06500	RESPIRATORY THERAPY	0.565362	102,560	57,984	65.00
66.00	06600	PHYSICAL THERAPY	0.635850	212,305	134,994	66.00
69.00	06900	ELECTROCARDIOLOGY	0.143832	224,295	32,261	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.648303	1,409,197	913,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.201693	4,025,009	811,816	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1.824703	6,051	11,041	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.688343	94,630	159,768	90.00
91.00	09100	EMERGENCY	2.163556	16,946	36,664	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.572173	99,593	156,577	92.00
200.00		Total (sum of lines 50-94 and 96-98)		12,280,038	3,371,941	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)		12,280,038		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140100	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/22/2016 5:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	406,674	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,289,766	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	939,064	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	69.64	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Date/Time Prepared: 11/22/2016 5:39 pm

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)	0.000001620	0.000003015	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	2,635,504		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	2,635,504	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	221,384	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	2,856,888	59.00
60.00	Primary payer payments	21,123	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	2,835,765	61.00
62.00	Deductibles billed to program beneficiaries	147,756	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	7,803	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	5,072	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	2,693,081	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	22,240	70.93
70.94	HRR adjustment amount (see instructions)	0	70.94
70.95	Recovery of accelerated depreciation	0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		21,959	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,693,362	71.00
71.01	Sequestration adjustment (see instructions)		53,867	71.01
72.00	Interim payments		2,640,542	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-1,047	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/22/2016 5:39 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	406,674	406,674		406,674	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,289,766		1,289,766	1,289,766	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	939,064	218,394	720,670	939,064	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,635,504	625,068	2,010,436	2,635,504	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,635,504	625,068	2,010,436	2,635,504	15.00
16.00	Payment for inpatient program capital	50.00	221,384	55,648	165,736	221,384	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			680,716	2,176,172	2,856,888	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/22/2016 5:39 pm

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	136,177	34,230	101,947	136,177	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	85,207	21,418	63,789	85,207	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	221,384	55,648	165,736	221,384	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	22,240	2,509	19,731	22,240	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	21,959	21,959	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140100	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part B Date/Time Prepared: 11/22/2016 5:39 pm
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	39,055	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	18,663,217	2.00
3.00	PPS payments	12,479,158	3.00
4.00	Outlier payment (see instructions)	57,916	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	39,055	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	206,327	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)	206,327	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 chargebasis 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)	206,327	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	167,272	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	39,055	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)	12,537,074	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)	2,136,829	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)	10,439,300	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)	10,439,300	30.00
31.00	Primary payer payments	653	31.00
32.00	Subtotal (line 30 minus line 31)	10,438,647	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)	146,747	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	95,386	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	10,534,033	37.00
38.00	MSP-LCC reconciliation amount from PS&R	479	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)	10,533,554	40.00
40.01	Sequestration adjustment (see instructions)	210,671	40.01
41.00	Interim payments	10,284,285	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	38,598	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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I Date/Time Prepared: 11/22/2016 5:39 pm

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		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		2,641,781		10,294,545	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	02/29/2016	1,239	02/29/2016	10,260	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-1,239		-10,260	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)		2,640,542		10,284,285	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		38,598	6.01
6.02	SETTLEMENT TO PROGRAM		1,047		0	6.02
7.00	Total Medicare program liability (see instructions)		2,639,495		10,322,883	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140100	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/22/2016 5:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,078	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	850	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	121	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	11,941	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,344,903,469	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	20,034,836	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	45,082	8.00
9.00	Sequestration adjustment amount (see instructions)	902	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	44,180	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	44,180	32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/22/2016 5:39 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	0	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	0	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	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	0	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	0	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	0	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)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	0	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				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)	0	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	0				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)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/22/2016 5:39 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		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-638,143,514				2.00
3.00	Total (sum of line 1 and line 2)		-638,143,514		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)		-638,143,514		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-638,143,514		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			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: 140100 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/22/2016 5:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	0		0	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)	0		0	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	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)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		638,143,514		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		638,143,514		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140100	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/22/2016 5:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	638,143,514	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-638,143,514	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-638,143,514	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-638,143,514	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140100	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/22/2016 5:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	136,177	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	85,207	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	32.63	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	221,384	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00