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: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/25/2016 11:13 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/25/2016 Time: 11:13 am
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. [5] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [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 MARION MEMORIAL HOSPITAL (140184) for the cost reporting period beginning 05/01/2015 and ending 04/30/2016 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	402,705	206,676	962	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	402,705	206,676	962	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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/22/2016 3:18 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 917 WEST MAIN ST	PO Box:			1.00
2.00	City: MARION	State: IL	Zip Code: 62959	County: WILLIAMSON	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	MARION MEMORIAL HOSPITAL	140184	16060	1	07/01/1996	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	MARION MEMORIAL HOSPITAL	14U184	16060		03/23/1999	N	P	N	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)	05/01/2015	04/30/2016	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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	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.	3,118	904	11	1	82	73	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

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		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 9/22/2016 3:18 pm

		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.	N	N	N	N	109.00

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	62,978	1,842,532	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.	Y		121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 9/22/2016 3:18 pm

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	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: CHS/COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD.	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	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)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/22/2016 3:18 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04/20/2015	07/18/2015	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: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/22/2016 3:18 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	08/16/2016	Y	08/16/2016	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)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 9/22/2016 3:18 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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	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.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				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.				Y	12/31/2015 38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	AMBER		WALKER		41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH CORP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3646		AMBER_WALKER@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/22/2016 3:18 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.	REVENUE MANAGER		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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 9/22/2016 3:18 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	80	29,280	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)		80	29,280	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	18	6,588	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		98	35,868	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)		98				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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 9/22/2016 3:18 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)	4,504	1,984	9,831			1.00
2.00	HMO and other (see instructions)	731	704				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)	4,504	1,984	9,831			7.00
8.00	INTENSIVE CARE UNIT	667	75	1,250			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,353	1,675			13.00
14.00	Total (see instructions)	5,171	3,412	12,756	0.00	354.58	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	354.58	27.00
28.00	Observation Bed Days		0	2,194			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	73	138			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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 9/22/2016 3:18 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	1,367	1,371	3,989	1.00
2.00	HMO and other (see instructions)			187	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	1,367	1,371	3,989	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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 9/22/2016 3:18 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	20,859,971	0	20,859,971	737,523.00	28.28	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)		106,943	18,060	125,003	3,742.00	33.41	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		265,186	0	265,186	6,485.10	40.89	11.00
12.00	Contract labor: Top level management and other management and administrative services		5,250	0	5,250	50.00	105.00	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		2,473,873	0	2,473,873	72,564.00	34.09	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)		5,695,234	0	5,695,234			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		31,405	0	31,405			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	126,638	0	126,638	3,936.00	32.17	26.00
27.00	Administrative & General	5.00	2,501,685	759,307	3,260,992	119,334.00	27.33	27.00
28.00	Administrative & General under contract (see inst.)		100,645	0	100,645	1,645.50	61.16	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	366,501	0	366,501	14,751.00	24.85	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,125,719	0	1,125,719	61,373.00	18.34	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		840,984	0	840,984	39,117.25	21.50	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,463,391	-834,501	628,890	13,627.00	46.15	38.00
39.00	Central Services and Supply	14.00	193,283	0	193,283	13,188.00	14.66	39.00
40.00	Pharmacy	15.00	947,509	0	947,509	23,563.00	40.21	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 9/22/2016 3:18 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	347,974	0	347,974	19,765.00	17.61	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 9/22/2016 3:18 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)		22,927,319	0	22,927,319	839,658.75	27.31	1.00
2.00	Excluded area salaries (see instructions)		106,943	18,060	125,003	3,742.00	33.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,820,376	-18,060	22,802,316	835,916.75	27.28	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,744,309	0	2,744,309	79,099.10	34.69	4.00
5.00	Subtotal wage-related costs (see inst.)		5,695,234	0	5,695,234	0.00	24.98	5.00
6.00	Total (sum of lines 3 thru 5)		31,259,919	-18,060	31,241,859	915,015.85	34.14	6.00
7.00	Total overhead cost (see instructions)		8,014,329	-75,194	7,939,135	310,299.75	25.59	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 9/22/2016 3:18 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	267,379	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)	2,895,244	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	22,412	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	16,686	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	97	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	12,291	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	723,290	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	1,208,617	17.00
18.00	Medicare Taxes - Employers Portion Only	282,660	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	180,451	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	117,511	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,726,638	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 9/22/2016 3:18 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet S-10 | Date/Time Prepared: 9/22/2016 3:18 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)	0.116993	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,932,168	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	14,724,861	5.00
6.00	Medicaid charges	149,742,861	6.00
7.00	Medicaid cost (line 1 times line 6)	17,518,867	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	912	9.00
10.00	Stand-alone SCHIP charges	30,262	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	3,540	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	2,628	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)	2,628	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	465,064	27,691	492,755	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	54,409	3,240	57,649	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)	54,409	3,240	57,649	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)	4,498,374	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	653,271	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,845,103	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	449,850	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	507,499	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	510,127	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A | Date/Time Prepared: 9/22/2016 3:18 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		1,185,036	1,185,036	1,365,301	2,550,337	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,141,094	4,141,094	1,021,008	5,162,102	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	126,638	135,993	262,631	3,983,941	4,246,572	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,501,685	4,966,800	7,468,485	-5,039,632	2,428,853	5.00
7.00	00700	OPERATION OF PLANT	366,501	1,945,662	2,312,163	0	2,312,163	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	250,303	250,303	0	250,303	8.00
9.00	00900	HOUSEKEEPING	0	1,135,906	1,135,906	0	1,135,906	9.00
10.00	01000	DIETARY	0	1,370,831	1,370,831	-473,711	897,120	10.00
11.00	01100	CAFETERIA	0	0	0	473,711	473,711	11.00
13.00	01300	NURSING ADMINISTRATION	1,463,391	267,825	1,731,216	-947,930	783,286	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	193,283	5,592,482	5,785,765	-5,299,648	486,117	14.00
15.00	01500	PHARMACY	947,509	3,662,824	4,610,333	-3,549,672	1,060,661	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	347,974	511,780	859,754	0	859,754	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,477,969	2,982,750	6,460,719	-209,247	6,251,472	30.00
31.00	03100	INTENSIVE CARE UNIT	1,217,434	391,361	1,608,795	0	1,608,795	31.00
43.00	04300	NURSERY	205,201	120,974	326,175	225,511	551,686	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,223,181	3,465,063	4,688,244	228,904	4,917,148	50.00
51.00	05100	RECOVERY ROOM	356,864	36,529	393,393	-393,393	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,085,916	101,668	1,187,584	-22,678	1,164,906	52.00
53.00	05300	ANESTHESIOLOGY	0	4,087,181	4,087,181	0	4,087,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,630,191	1,250,987	2,881,178	-243,132	2,638,046	54.00
54.01	05401	ULTRASOUND	166,936	84,771	251,707	-58,080	193,627	54.01
56.00	05600	RADIOISOTOPE	165,194	331,641	496,835	0	496,835	56.00
57.00	05700	CT SCAN	199,257	59,933	259,190	0	259,190	57.00
58.00	05800	MRI	82,434	9,205	91,639	0	91,639	58.00
60.00	06000	LABORATORY	953,083	2,054,606	3,007,689	-657,136	2,350,553	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	593,119	593,119	62.00
65.00	06500	RESPIRATORY THERAPY	461,180	166,345	627,525	-55,126	572,399	65.00
66.00	06600	PHYSICAL THERAPY	562,955	116,693	679,648	-43,959	635,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	106,296	8,206	114,502	0	114,502	67.00
68.00	06800	SPEECH PATHOLOGY	82,203	6,311	88,514	0	88,514	68.00
69.00	06900	ELECTROCARDIOLOGY	1,031,800	1,548,430	2,580,230	-57,115	2,523,115	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,053,685	2,053,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,162,522	3,162,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,432,759	3,432,759	73.00
74.00	07400	RENAL DIALYSIS	0	146,831	146,831	0	146,831	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	224,329	224,329	0	224,329	76.01
76.03	03951	WOUND CARE	176,545	115,882	292,427	-15,803	276,624	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,621,408	2,031,835	3,653,243	182,284	3,835,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	57,134	125,150	182,284	-182,284	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,810,162	44,633,217	65,443,379	-525,801	64,917,578	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	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	273	6,711	6,984	0	6,984	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	49,536	20,981	70,517	0	70,517	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	525,801	525,801	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	20,859,971	44,660,909	65,520,880	0	65,520,880	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A | Date/Time Prepared: 9/22/2016 3:18 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	647,458	3,197,795		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-890,723	4,271,379		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,987	4,243,585		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,354,986	12,783,839		5.00
7.00	00700	OPERATION OF PLANT	-13,014	2,299,149		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	250,303		8.00
9.00	00900	HOUSEKEEPING	0	1,135,906		9.00
10.00	01000	DIETARY	0	897,120		10.00
11.00	01100	CAFETERIA	-308,338	165,373		11.00
13.00	01300	NURSING ADMINISTRATION	-380	782,906		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	486,117		14.00
15.00	01500	PHARMACY	0	1,060,661		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-117	859,637		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,085,139	4,166,333		30.00
31.00	03100	INTENSIVE CARE UNIT	-128,919	1,479,876		31.00
43.00	04300	NURSERY	-52,618	499,068		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-814,827	4,102,321		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,164,906		52.00
53.00	05300	ANESTHESIOLOGY	-3,945,207	141,974		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-173,660	2,464,386		54.00
54.01	05401	ULTRASOUND	0	193,627		54.01
56.00	05600	RADIOISOTOPE	0	496,835		56.00
57.00	05700	CT SCAN	0	259,190		57.00
58.00	05800	MRI	0	91,639		58.00
60.00	06000	LABORATORY	0	2,350,553		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	593,119		62.00
65.00	06500	RESPIRATORY THERAPY	-250	572,149		65.00
66.00	06600	PHYSICAL THERAPY	0	635,689		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	114,502		67.00
68.00	06800	SPEECH PATHOLOGY	0	88,514		68.00
69.00	06900	ELECTROCARDIOLOGY	-780,902	1,742,213		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,053,685		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,162,522		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,432,759		73.00
74.00	07400	RENAL DIALYSIS	0	146,831		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	-208,656	15,673		76.01
76.03	03951	WOUND CARE	0	276,624		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,445,990	2,389,537		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	150,717	65,068,295		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
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,984		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	SENIOR CIRCLE	0	70,517		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0		194.00
194.01	07953	MARKETING	0	525,801		194.01
194.02	07952	NON ALLOWABLE MEALS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	150,717	65,671,597		200.00

RECLASSIFICATIONS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-6 | Date/Time Prepared: 9/22/2016 3:18 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,983,941	1.00
	TOTALS		0	3,983,941	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	42,066	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	42,066	
	C - RENTAL AND LEASES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,182,910	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,016,238	2.00
3.00		0.00	0	0	3.00
5.00		0.00	0	0	5.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	2,199,148	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	93,651	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	88,740	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,770	3.00
	TOTALS		0	187,161	
	E - MARKETING DEPARTMENT				
1.00	MARKETING	194.01	75,194	450,607	1.00
	TOTALS		75,194	450,607	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,011,619	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,162,522	2.00
3.00	OPERATING ROOM	50.00	0	182,008	3.00
	TOTALS		0	5,356,149	
	G - DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,432,759	1.00
	TOTALS		0	3,432,759	
	H - LABOR AND DELIVERY COSTS				
1.00	NURSERY	43.00	198,401	27,110	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	124,823	2.00
	TOTALS		198,401	151,933	
	J - NURSING ADMIN COSTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	834,501	113,429	1.00
	TOTALS		834,501	113,429	
	K - MISCELLANEOUS DEPARTMENTS				
1.00	OPERATING ROOM	50.00	356,864	36,529	1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	27,051	566,068	2.00
3.00	EMERGENCY	91.00	57,134	125,150	3.00
	TOTALS		441,049	727,747	
	M - PORTION OF DIETARY COST TO CAFETERIA				
1.00	CAFETERIA	11.00	0	473,711	1.00
	TOTALS		0	473,711	
500.00	Grand Total: Increases		1,549,145	17,118,651	500.00

RECLASSIFICATIONS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-6 | Date/Time Prepared: 9/22/2016 3:18 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,983,941	0		1.00
	TOTALS		0	3,983,941			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	158	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	32,264	0		2.00
3.00	WOUND CARE	76.03	0	9,644	0		3.00
	TOTALS		0	42,066			
	C - RENTAL AND LEASES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,290,659	10		1.00
2.00	PHARMACY	15.00	0	116,913	10		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	6,414	0		3.00
5.00	OPERATING ROOM	50.00	0	346,497	0		5.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	243,132	0		7.00
8.00	ULTRASOUND	54.01	0	58,080	0		8.00
9.00	LABORATORY	60.00	0	64,017	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	22,862	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	43,959	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	456	0		12.00
13.00	WOUND CARE	76.03	0	6,159	0		13.00
	TOTALS		0	2,199,148			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	187,161	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	187,161			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	75,194	450,607	0		1.00
	TOTALS		75,194	450,607			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,299,490	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	56,659	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	5,356,149			
	G - DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	3,432,759	0		1.00
	TOTALS		0	3,432,759			
	H - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	50,900	151,933	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	147,501	0	0		2.00
	TOTALS		198,401	151,933			
	J - NURSING ADMIN COSTS						
1.00	NURSING ADMINISTRATION	13.00	834,501	113,429	0		1.00
	TOTALS		834,501	113,429			
	K - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	356,864	36,529	0		1.00
2.00	LABORATORY	60.00	27,051	566,068	0		2.00
3.00	AMBULANCE SERVICES	95.00	57,134	125,150	0		3.00
	TOTALS		441,049	727,747			
	M - PORTION OF DIETARY COST TO CAFETERIA						
1.00	DIETARY	10.00	0	473,711	0		1.00
	TOTALS		0	473,711			
500.00	Grand Total: Decreases		1,549,145	17,118,651			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 9/22/2016 3:18 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,393,860	0	0	0	0	1.00
2.00	Land Improvements	562,648	0	0	0	0	2.00
3.00	Buildings and Fixtures	46,974,794	14,771	0	14,771	0	3.00
4.00	Building Improvements	3,475,011	616,556	0	616,556	12,216	4.00
5.00	Fixed Equipment	2,278,176	38,962	0	38,962	15,798	5.00
6.00	Movable Equipment	24,464,866	1,686,899	0	1,686,899	536,742	6.00
7.00	HIT designated Assets	6,556,261	835	0	835	0	7.00
8.00	Subtotal (sum of lines 1-7)	85,705,616	2,358,023	0	2,358,023	564,756	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	85,705,616	2,358,023	0	2,358,023	564,756	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,393,860	0	1.00
2.00	Land Improvements	562,648	0	2.00
3.00	Buildings and Fixtures	46,989,565	0	3.00
4.00	Building Improvements	4,079,351	0	4.00
5.00	Fixed Equipment	2,301,340	0	5.00
6.00	Movable Equipment	25,615,023	0	6.00
7.00	HIT designated Assets	6,557,096	0	7.00
8.00	Subtotal (sum of lines 1-7)	87,498,883	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	87,498,883	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 9/22/2016 3:18 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	1,185,036	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,141,094	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,326,130	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,185,036	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,141,094	2.00
3.00	Total (sum of lines 1-2)	0	5,326,130	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 9/22/2016 3:18 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	53,025,424	0	53,025,424	0.606013	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34,473,458	0	34,473,458	0.393987	0	2.00
3.00	Total (sum of lines 1-2)	87,498,882	0	87,498,882	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,586,727	1,179,793	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,057,422	1,016,238	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,644,149	2,196,031	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	248,884	93,651	88,740	0	3,197,795	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	192,949	4,770	0	0	4,271,379	2.00
3.00	Total (sum of lines 1-2)	441,833	98,421	88,740	0	7,469,174	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8 | Date/Time Prepared: 9/22/2016 3:18 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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-3,117	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-34,415	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,578,073			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	14,862,534			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-308,338	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-117	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-380	NURSING ADMINISTRATION	13.00	0	19.00
20.00	Vending machines	B	-2,074	ADMINISTRATIVE & GENERAL	5.00	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	401,691	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,060,621	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	A	-2,150	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	EMPLOYEE GIFTS	A	-14,396	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8 | Date/Time Prepared: 9/22/2016 3:18 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			0		0.00	0	33.02
33.03	PATIENT PHONE BENEFIT EXPENSE	A	-2,987	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	PATIENT PHONE DEPRECIATION EXPENSE	A	-5,222	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.04
33.05	PATIENT TV DEPRECIATION EXPENSE	A	-23,046	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING EXPENSES	A	-106,476	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07			0		0.00	0	33.07
33.08	PHYSICIAN RECRUITING	A	-105,614	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOBBYING EXPENSE	A	-29,802	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	CHARITABLE CONTRIBUTIONS	A	-5,798	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	GIFT SHOP	A	-4,733	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	ILLINOIS PROVIDER TAX	A	-3,520,792	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	CRNA COST	A	-58,095	ANESTHESIOLOGY	53.00	0	33.13
33.14	LEGAL COSTS	A	-222,119	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	PENALTIES/LATE CHARGES	A	535	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	SPECIAL EVENTS	A	-1,362	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	POLITICAL CONTRIBUTIONS	A	-8,875	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	LATE CHARGES	A	-2,427	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	PATIENT TV CABLE EXPENSE	A	-13,014	OPERATION OF PLANT	7.00	0	33.19
33.20			0		0.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		150,717				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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 9/22/2016 3:18 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELAT INTEREST	202,259	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	494,417	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	33,245	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAP BLDG & FIXTURES	13,380	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL MOVEABLE EQUIP	184,825	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HOME OFFICE COST	2,224,734	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	1,905,510	523,616	4.03
4.04	2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	219,301	211,177	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-12,609,578	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	1,090,191	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	4,997	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	37,293	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	1,339,242	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICE CENTER ALLOCA	249,501	0	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	QHC SPECIFIC COSTS & OFFSET	583,010	0	4.11
4.14	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	69,339	4.14
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	437,861	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	37,597	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN COLLECTION FEES	0	111,130	4.19
4.23	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	5,217	0	4.23
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			6,115,399	-8,747,135	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	B		0.00	CHS, INC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet A-8-1 Date/Time Prepared: 9/22/2016 3:18 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	202,259	11		1.00
2.00	494,417	0		2.00
3.00	33,245	11		3.00
4.00	13,380	11		4.00
4.01	184,825	11		4.01
4.02	2,224,734	0		4.02
4.03	1,381,894	0		4.03
4.04	8,124	11		4.04
4.05	12,609,578	0		4.05
4.06	-1,090,191	0		4.06
4.07	-4,997	0		4.07
4.08	-37,293	0		4.08
4.09	-1,339,242	0		4.09
4.10	249,501	0		4.10
4.11	583,010	0		4.11
4.14	-69,339	0		4.14
4.17	-437,861	0		4.17
4.18	-37,597	0		4.18
4.19	-111,130	0		4.19
4.23	5,217	9		4.23
5.00	14,862,534			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	HOSPITAL CORPOR		6.00
7.00	COLLECTION AGEN		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 9/22/2016 3:18 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,085,139	2,085,139	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	128,919	128,919	0	0	0	2.00
3.00	43.00	NURSERY	52,618	52,618	0	0	0	3.00
4.00	50.00	OPERATING ROOM	814,827	814,827	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	3,887,112	3,887,112	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	173,660	173,660	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	250	250	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	780,902	780,902	0	0	0	8.00
9.00	91.00	EMERGENCY	1,445,990	1,445,990	0	0	0	9.00
10.00	76.01	SLEEP LAB	208,656	208,656	0	0	0	10.00
200.00			9,578,073	9,578,073	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	43.00	NURSERY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	76.01	SLEEP LAB	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	30.00	ADULTS & PEDIATRICS	0	0	0	2,085,139		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	128,919		2.00
3.00	43.00	NURSERY	0	0	0	52,618		3.00
4.00	50.00	OPERATING ROOM	0	0	0	814,827		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	3,887,112		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	173,660		6.00
7.00	65.00	RESPIRATORY THERAPY	0	0	0	250		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	780,902		8.00
9.00	91.00	EMERGENCY	0	0	0	1,445,990		9.00
10.00	76.01	SLEEP LAB	0	0	0	208,656		10.00
200.00			0	0	0	9,578,073		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,197,795	3,197,795				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,271,379		4,271,379			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,243,585	16,413	21,923	4,281,921		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,783,839	323,974	432,740	673,473	14,214,026	5.00
7.00	00700	OPERATION OF PLANT	2,299,149	695,010	928,347	75,691	3,998,197	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	250,303	6,739	9,001	0	266,043	8.00
9.00	00900	HOUSEKEEPING	1,135,906	18,274	24,409	0	1,178,589	9.00
10.00	01000	DIETARY	897,120	49,795	66,513	0	1,013,428	10.00
11.00	01100	CAFETERIA	165,373	56,276	75,169	0	296,818	11.00
13.00	01300	NURSING ADMINISTRATION	782,906	77,580	103,625	129,881	1,093,992	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	486,117	31,670	42,303	39,918	600,008	14.00
15.00	01500	PHARMACY	1,060,661	28,804	38,474	195,683	1,323,622	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	859,637	46,602	62,248	71,865	1,040,352	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,166,333	502,597	671,333	707,763	6,048,026	30.00
31.00	03100	INTENSIVE CARE UNIT	1,479,876	166,355	222,205	251,429	2,119,865	31.00
43.00	04300	NURSERY	499,068	26,983	36,042	83,353	645,446	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,102,321	278,920	372,561	326,317	5,080,119	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,164,906	65,080	86,929	193,805	1,510,720	52.00
53.00	05300	ANESTHESIOLOGY	141,974	8,084	10,798	0	160,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,464,386	99,047	132,299	336,674	3,032,406	54.00
54.01	05401	ULTRASOUND	193,627	28,342	37,857	34,476	294,302	54.01
56.00	05600	RADIOISOTOPE	496,835	9,388	12,540	34,117	552,880	56.00
57.00	05700	CT SCAN	259,190	16,331	21,814	41,151	338,486	57.00
58.00	05800	MRI	91,639	17,350	23,175	17,025	149,189	58.00
60.00	06000	LABORATORY	2,350,553	64,374	85,985	191,248	2,692,160	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	593,119	3,424	4,573	5,587	606,703	62.00
65.00	06500	RESPIRATORY THERAPY	572,149	14,742	19,691	95,245	701,827	65.00
66.00	06600	PHYSICAL THERAPY	635,689	88,925	118,779	116,264	959,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,502	2,242	2,994	21,953	141,691	67.00
68.00	06800	SPEECH PATHOLOGY	88,514	1,264	1,688	16,977	108,443	68.00
69.00	06900	ELECTROCARDIOLOGY	1,742,213	56,928	76,040	213,091	2,088,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,053,685	0	0	0	2,053,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,162,522	0	0	0	3,162,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,432,759	0	0	0	3,432,759	73.00
74.00	07400	RENAL DIALYSIS	146,831	4,538	6,061	0	157,430	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	15,673	32,010	42,757	0	90,440	76.01
76.03	03951	WOUND CARE	276,624	38,233	51,069	36,461	402,387	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,389,537	129,589	173,096	346,659	3,038,881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,068,295	3,005,883	4,015,038	4,256,106	64,594,227	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,185	12,268	0	21,453	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,984	179,344	239,554	56	425,938	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	70,517	3,383	4,519	10,230	88,649	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	525,801	0	0	15,529	541,330	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	65,671,597	3,197,795	4,271,379	4,281,921	65,671,597	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,214,026					5.00
7.00	00700	OPERATION OF PLANT	1,104,414	5,102,611				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,489	15,902	355,434			8.00
9.00	00900	HOUSEKEEPING	325,559	43,121	0	1,547,269		9.00
10.00	01000	DIETARY	279,937	117,502	0	36,047	1,446,914	10.00
11.00	01100	CAFETERIA	81,989	132,794	0	40,739	759,289	11.00
13.00	01300	NURSING ADMINISTRATION	302,191	183,065	0	56,161	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	165,739	74,733	0	22,927	0	14.00
15.00	01500	PHARMACY	365,621	67,968	0	20,851	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	287,374	109,967	0	33,736	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,670,642	1,185,980	166,703	363,832	250,069	30.00
31.00	03100	INTENSIVE CARE UNIT	585,566	392,548	28,281	120,426	31,361	31.00
43.00	04300	NURSERY	178,290	63,672	0	19,533	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,403,271	658,169	48,497	201,913	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	417,303	153,569	0	47,112	0	52.00
53.00	05300	ANESTHESIOLOGY	44,433	19,076	1,101	5,852	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	837,635	233,721	16,734	71,701	0	54.00
54.01	05401	ULTRASOUND	81,294	66,878	0	20,517	0	54.01
56.00	05600	RADIOISOTOPE	152,721	22,154	0	6,796	0	56.00
57.00	05700	CT SCAN	93,499	38,537	0	11,822	0	57.00
58.00	05800	MRI	41,210	40,941	0	12,560	0	58.00
60.00	06000	LABORATORY	743,650	151,902	0	46,601	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	167,588	8,079	0	2,479	0	62.00
65.00	06500	RESPIRATORY THERAPY	193,864	34,786	0	10,671	0	65.00
66.00	06600	PHYSICAL THERAPY	265,084	209,836	7,355	64,373	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,139	5,290	0	1,623	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,955	2,982	0	915	0	68.00
69.00	06900	ELECTROCARDIOLOGY	576,839	134,333	19,399	41,211	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	567,285	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	873,577	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	948,224	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	43,487	10,708	0	3,285	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	24,982	75,534	1,848	23,172	0	76.01
76.03	03951	WOUND CARE	111,151	90,218	320	27,677	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	839,424	305,792	65,054	93,811	14,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,916,426	4,649,757	355,292	1,408,343	1,055,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,926	21,673	0	6,649	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	117,656	423,198	142	129,828	24,318	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	24,487	7,983	0	2,449	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	149,531	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	367,115	194.02
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)	14,214,026	5,102,611	355,434	1,547,269	1,446,914	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,311,629					11.00
13.00	01300	NURSING ADMINISTRATION	29,711	1,665,120				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,758	0	892,165			14.00
15.00	01500	PHARMACY	51,393	0	3,186	1,832,641		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,092	0	1,014	0	1,515,535	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	277,603	433,668	44,915	0	104,265	30.00
31.00	03100	INTENSIVE CARE UNIT	72,213	154,057	9,810	0	16,537	31.00
43.00	04300	NURSERY	30,482	51,072	4,512	0	8,662	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	133,630	199,942	187,065	0	212,552	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,634	118,749	1,018	0	12,034	52.00
53.00	05300	ANESTHESIOLOGY	0	0	11,429	0	37,500	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,342	206,288	5,278	0	40,817	54.00
54.01	05401	ULTRASOUND	11,612	21,124	1,178	0	14,580	54.01
56.00	05600	RADIOISOTOPE	10,297	20,904	219	0	50,230	56.00
57.00	05700	CT SCAN	16,420	25,214	3,921	0	93,516	57.00
58.00	05800	MRI	5,489	10,431	98	0	19,593	58.00
60.00	06000	LABORATORY	107,231	0	56,608	0	215,720	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,130	0	3,098	0	13,405	62.00
65.00	06500	RESPIRATORY THERAPY	41,913	58,359	5,292	0	30,550	65.00
66.00	06600	PHYSICAL THERAPY	38,692	0	1,138	0	21,019	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,754	0	0	0	5,289	67.00
68.00	06800	SPEECH PATHOLOGY	4,264	0	0	0	2,195	68.00
69.00	06900	ELECTROCARDIOLOGY	78,246	130,566	27,454	0	188,292	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	186,218	0	30,642	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	292,754	0	100,878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,832,641	134,104	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,751	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	1,290	0	5,952	76.01
76.03	03951	WOUND CARE	15,332	22,340	4,169	0	4,611	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	109,272	212,406	40,289	0	149,841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,303,510	1,665,120	891,953	1,832,641	1,515,535	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	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	3,946	0	21	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	4,173	0	191	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,311,629	1,665,120	892,165	1,832,641	1,515,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part I | Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	10,545,703	0	10,545,703		30.00
31.00	03100	INTENSIVE CARE UNIT	3,530,664	0	3,530,664		31.00
43.00	04300	NURSERY	1,001,669	0	1,001,669		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,125,158	0	8,125,158		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,327,139	0	2,327,139		52.00
53.00	05300	ANESTHESIOLOGY	280,247	0	280,247		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,563,922	0	4,563,922		54.00
54.01	05401	ULTRASOUND	511,485	0	511,485		54.01
56.00	05600	RADIOISOTOPE	816,201	0	816,201		56.00
57.00	05700	CT SCAN	621,415	0	621,415		57.00
58.00	05800	MRI	279,511	0	279,511		58.00
60.00	06000	LABORATORY	4,013,872	0	4,013,872		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	804,482	0	804,482		62.00
65.00	06500	RESPIRATORY THERAPY	1,077,262	0	1,077,262		65.00
66.00	06600	PHYSICAL THERAPY	1,567,154	0	1,567,154		66.00
67.00	06700	OCCUPATIONAL THERAPY	201,786	0	201,786		67.00
68.00	06800	SPEECH PATHOLOGY	148,754	0	148,754		68.00
69.00	06900	ELECTROCARDIOLOGY	3,284,612	0	3,284,612		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,837,830	0	2,837,830		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,429,731	0	4,429,731		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,347,728	0	6,347,728		73.00
74.00	07400	RENAL DIALYSIS	217,661	0	217,661		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	223,218	0	223,218		76.01
76.03	03951	WOUND CARE	678,205	0	678,205		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	4,869,532	0	4,869,532		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,304,941	0	63,304,941		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	55,701	0	55,701		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,121,080	0	1,121,080		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	127,535	0	127,535		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0		194.00
194.01	07953	MARKETING	695,225	0	695,225		194.01
194.02	07952	NON ALLOWABLE MEALS	367,115	0	367,115		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	65,671,597	0	65,671,597		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/22/2016 3:18 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	16,413	21,923	38,336	38,336	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	323,974	432,740	756,714	6,030	5.00
7.00	00700	OPERATION OF PLANT	0	695,010	928,347	1,623,357	678	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,739	9,001	15,740	0	8.00
9.00	00900	HOUSEKEEPING	0	18,274	24,409	42,683	0	9.00
10.00	01000	DIETARY	0	49,795	66,513	116,308	0	10.00
11.00	01100	CAFETERIA	0	56,276	75,169	131,445	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	77,580	103,625	181,205	1,163	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,670	42,303	73,973	357	14.00
15.00	01500	PHARMACY	0	28,804	38,474	67,278	1,752	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,602	62,248	108,850	643	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	502,597	671,333	1,173,930	6,336	30.00
31.00	03100	INTENSIVE CARE UNIT	0	166,355	222,205	388,560	2,251	31.00
43.00	04300	NURSERY	0	26,983	36,042	63,025	746	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	278,920	372,561	651,481	2,922	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	65,080	86,929	152,009	1,735	52.00
53.00	05300	ANESTHESIOLOGY	0	8,084	10,798	18,882	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	99,047	132,299	231,346	3,014	54.00
54.01	05401	ULTRASOUND	0	28,342	37,857	66,199	309	54.01
56.00	05600	RADIOISOTOPE	0	9,388	12,540	21,928	305	56.00
57.00	05700	CT SCAN	0	16,331	21,814	38,145	368	57.00
58.00	05800	MRI	0	17,350	23,175	40,525	152	58.00
60.00	06000	LABORATORY	0	64,374	85,985	150,359	1,712	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,424	4,573	7,997	50	62.00
65.00	06500	RESPIRATORY THERAPY	0	14,742	19,691	34,433	853	65.00
66.00	06600	PHYSICAL THERAPY	0	88,925	118,779	207,704	1,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,242	2,994	5,236	197	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,264	1,688	2,952	152	68.00
69.00	06900	ELECTROCARDIOLOGY	0	56,928	76,040	132,968	1,908	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,538	6,061	10,599	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	32,010	42,757	74,767	0	76.01
76.03	03951	WOUND CARE	0	38,233	51,069	89,302	326	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	129,589	173,096	302,685	3,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,005,883	4,015,038	7,020,921	38,104	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,185	12,268	21,453	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	179,344	239,554	418,898	1	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	0	3,383	4,519	7,902	92	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	139	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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	3,197,795	4,271,379	7,469,174	38,336	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	762,744					5.00
7.00	00700	OPERATION OF PLANT	59,265	1,683,300				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,944	5,246	24,930			8.00
9.00	00900	HOUSEKEEPING	17,470	14,225	0	74,378		9.00
10.00	01000	DIETARY	15,022	38,763	0	1,733	171,826	10.00
11.00	01100	CAFETERIA	4,400	43,808	0	1,958	90,168	11.00
13.00	01300	NURSING ADMINISTRATION	16,216	60,391	0	2,700	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,894	24,654	0	1,102	0	14.00
15.00	01500	PHARMACY	19,620	22,422	0	1,002	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,421	36,277	0	1,622	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	89,641	391,241	11,691	17,489	29,697	30.00
31.00	03100	INTENSIVE CARE UNIT	31,423	129,498	1,984	5,789	3,724	31.00
43.00	04300	NURSERY	9,567	21,005	0	939	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	75,303	217,123	3,402	9,706	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,393	50,661	0	2,265	0	52.00
53.00	05300	ANESTHESIOLOGY	2,384	6,293	77	281	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,949	77,102	1,174	3,447	0	54.00
54.01	05401	ULTRASOUND	4,362	22,062	0	986	0	54.01
56.00	05600	RADIOISOTOPE	8,195	7,308	0	327	0	56.00
57.00	05700	CT SCAN	5,017	12,713	0	568	0	57.00
58.00	05800	MRI	2,211	13,506	0	604	0	58.00
60.00	06000	LABORATORY	39,906	50,111	0	2,240	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,993	2,665	0	119	0	62.00
65.00	06500	RESPIRATORY THERAPY	10,403	11,475	0	513	0	65.00
66.00	06600	PHYSICAL THERAPY	14,225	69,223	516	3,094	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,100	1,745	0	78	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,607	984	0	44	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,954	44,315	1,361	1,981	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,442	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,878	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,884	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,334	3,533	0	158	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,341	24,918	130	1,114	0	76.01
76.03	03951	WOUND CARE	5,965	29,762	22	1,330	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	45,045	100,878	4,563	4,510	1,753	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	746,774	1,533,907	24,920	67,699	125,342	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	318	7,150	0	320	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,314	139,609	10	6,241	2,888	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	1,314	2,634	0	118	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	8,024	0	0	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	43,596	194.02
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)	762,744	1,683,300	24,930	74,378	171,826	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	271,779					11.00
13.00	01300	NURSING ADMINISTRATION	6,156	267,831				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,959	0	114,939			14.00
15.00	01500	PHARMACY	10,649	0	410	123,133		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,929	0	131	0	171,873	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,521	69,755	5,786	0	11,837	30.00
31.00	03100	INTENSIVE CARE UNIT	14,963	24,780	1,264	0	1,877	31.00
43.00	04300	NURSERY	6,316	8,215	581	0	983	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,689	32,160	24,100	0	24,131	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,807	19,100	131	0	1,366	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,472	0	4,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,729	33,181	680	0	4,634	54.00
54.01	05401	ULTRASOUND	2,406	3,398	152	0	1,655	54.01
56.00	05600	RADIOISOTOPE	2,134	3,362	28	0	5,703	56.00
57.00	05700	CT SCAN	3,402	4,056	505	0	10,617	57.00
58.00	05800	MRI	1,137	1,678	13	0	2,224	58.00
60.00	06000	LABORATORY	22,219	0	7,293	0	24,307	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	649	0	399	0	1,522	62.00
65.00	06500	RESPIRATORY THERAPY	8,685	9,387	682	0	3,468	65.00
66.00	06600	PHYSICAL THERAPY	8,017	0	147	0	2,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,814	0	0	0	600	67.00
68.00	06800	SPEECH PATHOLOGY	883	0	0	0	249	68.00
69.00	06900	ELECTROCARDIOLOGY	16,213	21,001	3,537	0	21,377	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	23,991	0	3,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	37,716	0	11,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	123,133	15,225	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	312	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	166	0	676	76.01
76.03	03951	WOUND CARE	3,177	3,593	537	0	523	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	22,642	34,165	5,190	0	17,012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	270,096	267,831	114,911	123,133	171,873	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	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	818	0	3	0	0	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	865	0	25	0	0	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
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)	271,779	267,831	114,939	123,133	171,873	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B Part II | Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,864,924	0	1,864,924		30.00
31.00	03100	INTENSIVE CARE UNIT	606,113	0	606,113		31.00
43.00	04300	NURSERY	111,377	0	111,377		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,068,017	0	1,068,017		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	263,467	0	263,467		52.00
53.00	05300	ANESTHESIOLOGY	33,646	0	33,646		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	424,256	0	424,256		54.00
54.01	05401	ULTRASOUND	101,529	0	101,529		54.01
56.00	05600	RADIOISOTOPE	49,290	0	49,290		56.00
57.00	05700	CT SCAN	75,391	0	75,391		57.00
58.00	05800	MRI	62,050	0	62,050		58.00
60.00	06000	LABORATORY	298,147	0	298,147		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,394	0	22,394		62.00
65.00	06500	RESPIRATORY THERAPY	79,899	0	79,899		65.00
66.00	06600	PHYSICAL THERAPY	306,353	0	306,353		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,770	0	11,770		67.00
68.00	06800	SPEECH PATHOLOGY	6,871	0	6,871		68.00
69.00	06900	ELECTROCARDIOLOGY	275,615	0	275,615		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	57,912	0	57,912		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,047	0	96,047		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	189,242	0	189,242		73.00
74.00	07400	RENAL DIALYSIS	16,936	0	16,936		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	103,112	0	103,112		76.01
76.03	03951	WOUND CARE	134,537	0	134,537		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	541,547	0	541,547		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,800,442	0	6,800,442		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,241	0	29,241		190.00
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	573,961	0	573,961		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	12,881	0	12,881		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0		194.00
194.01	07953	MARKETING	9,053	0	9,053		194.01
194.02	07952	NON ALLOWABLE MEALS	43,596	0	43,596		194.02
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	7,469,174	0	7,469,174		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	235,363					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		235,363				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,208	1,208	20,733,333			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,845	23,845	3,260,992	-14,214,026	51,457,571	5.00
7.00	00700	OPERATION OF PLANT	51,154	51,154	366,501	0	3,998,197	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	496	0	0	266,043	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	0	0	1,178,589	9.00
10.00	01000	DIETARY	3,665	3,665	0	0	1,013,428	10.00
11.00	01100	CAFETERIA	4,142	4,142	0	0	296,818	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	5,710	628,890	0	1,093,992	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	2,331	193,283	0	600,008	14.00
15.00	01500	PHARMACY	2,120	2,120	947,509	0	1,323,622	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	3,430	347,974	0	1,040,352	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,992	36,992	3,427,069	0	6,048,026	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	12,244	1,217,434	0	2,119,865	31.00
43.00	04300	NURSERY	1,986	1,986	403,602	0	645,446	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,529	20,529	1,580,045	0	5,080,119	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	4,790	938,415	0	1,510,720	52.00
53.00	05300	ANESTHESIOLOGY	595	595	0	0	160,856	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	7,290	1,630,191	0	3,032,406	54.00
54.01	05401	ULTRASOUND	2,086	2,086	166,936	0	294,302	54.01
56.00	05600	RADIOISOTOPE	691	691	165,194	0	552,880	56.00
57.00	05700	CT SCAN	1,202	1,202	199,257	0	338,486	57.00
58.00	05800	MRI	1,277	1,277	82,434	0	149,189	58.00
60.00	06000	LABORATORY	4,738	4,738	926,032	0	2,692,160	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	252	27,051	0	606,703	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	1,085	461,180	0	701,827	65.00
66.00	06600	PHYSICAL THERAPY	6,545	6,545	562,955	0	959,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	165	106,296	0	141,691	67.00
68.00	06800	SPEECH PATHOLOGY	93	93	82,203	0	108,443	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	4,190	1,031,800	0	2,088,272	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,053,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,162,522	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,432,759	73.00
74.00	07400	RENAL DIALYSIS	334	334	0	0	157,430	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	2,356	0	0	90,440	76.01
76.03	03951	WOUND CARE	2,814	2,814	176,545	0	402,387	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	9,538	1,678,542	0	3,038,881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	221,238	221,238	20,608,330	-14,214,026	50,380,201	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	676	0	0	21,453	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	13,200	273	0	425,938	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	249	49,536	0	88,649	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	75,194	0	541,330	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,197,795	4,271,379	4,281,921		14,214,026	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.586651	18.148048	0.206524		0.276228	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			38,336		762,744	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001849		0.014823	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	159,156					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	496	10,004				8.00
9.00	00900	HOUSEKEEPING	1,345	0	157,315			9.00
10.00	01000	DIETARY	3,665	0	3,665	155,946		10.00
11.00	01100	CAFETERIA	4,142	0	4,142	81,835	28,916	11.00
13.00	01300	NURSING ADMINISTRATION	5,710	0	5,710	0	655	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,331	0	2,331	0	634	14.00
15.00	01500	PHARMACY	2,120	0	2,120	0	1,133	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,430	0	3,430	0	950	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,992	4,692	36,992	26,952	6,120	30.00
31.00	03100	INTENSIVE CARE UNIT	12,244	796	12,244	3,380	1,592	31.00
43.00	04300	NURSERY	1,986	0	1,986	0	672	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,529	1,365	20,529	0	2,946	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,790	0	4,790	0	1,469	52.00
53.00	05300	ANESTHESIOLOGY	595	31	595	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,290	471	7,290	0	2,631	54.00
54.01	05401	ULTRASOUND	2,086	0	2,086	0	256	54.01
56.00	05600	RADIOISOTOPE	691	0	691	0	227	56.00
57.00	05700	CT SCAN	1,202	0	1,202	0	362	57.00
58.00	05800	MRI	1,277	0	1,277	0	121	58.00
60.00	06000	LABORATORY	4,738	0	4,738	0	2,364	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	252	0	252	0	69	62.00
65.00	06500	RESPIRATORY THERAPY	1,085	0	1,085	0	924	65.00
66.00	06600	PHYSICAL THERAPY	6,545	207	6,545	0	853	66.00
67.00	06700	OCCUPATIONAL THERAPY	165	0	165	0	193	67.00
68.00	06800	SPEECH PATHOLOGY	93	0	93	0	94	68.00
69.00	06900	ELECTROCARDIOLOGY	4,190	546	4,190	0	1,725	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	334	0	334	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,356	52	2,356	0	0	76.01
76.03	03951	WOUND CARE	2,814	9	2,814	0	338	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,538	1,831	9,538	1,591	2,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	145,031	10,000	143,190	113,758	28,737	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	676	0	676	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,200	4	13,200	2,621	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	SENIOR CIRCLE	249	0	249	0	87	193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0	0	194.00
194.01	07953	MARKETING	0	0	0	0	92	194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	39,567	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,102,611	355,434	1,547,269	1,446,914	1,311,629	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.060438	35.529188	9.835483	9.278301	45.359974	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,683,300	24,930	74,378	171,826	271,779	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.576416	2.492003	0.472797	1.101830	9.398914	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet B-1 | Date/Time Prepared: 9/22/2016 3:18 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	13,158,643					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,637,664				14.00
15.00	01500	PHARMACY	0	34,415	3,432,759			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,952	0	541,100,435		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,427,069	485,196	0	37,224,342		30.00
31.00	03100	INTENSIVE CARE UNIT	1,217,434	105,978	0	5,903,796		31.00
43.00	04300	NURSERY	403,601	48,745	0	3,092,637		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,580,044	2,020,775	0	75,884,337		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	938,415	10,997	0	4,296,391		52.00
53.00	05300	ANESTHESIOLOGY	0	123,458	0	13,387,933		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,630,191	57,012	0	14,572,463		54.00
54.01	05401	ULTRASOUND	166,936	12,723	0	5,205,233		54.01
56.00	05600	RADIOISOTOPE	165,194	2,366	0	17,933,035		56.00
57.00	05700	CT SCAN	199,257	42,352	0	33,386,475		57.00
58.00	05800	MRI	82,434	1,061	0	6,995,171		58.00
60.00	06000	LABORATORY	0	611,505	0	77,045,688		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	33,462	0	4,785,760		62.00
65.00	06500	RESPIRATORY THERAPY	461,180	57,165	0	10,906,956		65.00
66.00	06600	PHYSICAL THERAPY	0	12,294	0	7,504,244		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,888,263		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	783,736		68.00
69.00	06900	ELECTROCARDIOLOGY	1,031,800	296,573	0	67,222,999		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,011,619	0	10,939,727		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,162,522	0	36,015,146		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,432,759	47,877,094		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	982,281		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	13,932	0	2,124,945		76.01
76.03	03951	WOUND CARE	176,545	45,041	0	1,646,074		76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,678,543	435,222	0	53,495,709		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,158,643	9,635,365	3,432,759	541,100,435		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191.00	19100	RESEARCH	0	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	SENIOR CIRCLE	0	232	0	0		193.01
194.00	07950	OTHER NON-REIMBURSABLE	0	0	0	0		194.00
194.01	07953	MARKETING	0	2,067	0	0		194.01
194.02	07952	NON ALLOWABLE MEALS	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,665,120	892,165	1,832,641	1,515,535		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.126542	0.092571	0.533868	0.002801		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	267,831	114,939	123,133	171,873		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.020354	0.011926	0.035870	0.000318		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/22/2016 3:18 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	10,545,703		10,545,703	0	10,545,703	30.00
31.00	03100	INTENSIVE CARE UNIT	3,530,664		3,530,664	0	3,530,664	31.00
43.00	04300	NURSERY	1,001,669		1,001,669	0	1,001,669	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,125,158		8,125,158	0	8,125,158	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,327,139		2,327,139	0	2,327,139	52.00
53.00	05300	ANESTHESIOLOGY	280,247		280,247	0	280,247	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,563,922		4,563,922	0	4,563,922	54.00
54.01	05401	ULTRASOUND	511,485		511,485	0	511,485	54.01
56.00	05600	RADIOISOTOPE	816,201		816,201	0	816,201	56.00
57.00	05700	CT SCAN	621,415		621,415	0	621,415	57.00
58.00	05800	MRI	279,511		279,511	0	279,511	58.00
60.00	06000	LABORATORY	4,013,872		4,013,872	0	4,013,872	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	804,482		804,482	0	804,482	62.00
65.00	06500	RESPIRATORY THERAPY	1,077,262	0	1,077,262	0	1,077,262	65.00
66.00	06600	PHYSICAL THERAPY	1,567,154	0	1,567,154	0	1,567,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	201,786	0	201,786	0	201,786	67.00
68.00	06800	SPEECH PATHOLOGY	148,754	0	148,754	0	148,754	68.00
69.00	06900	ELECTROCARDIOLOGY	3,284,612		3,284,612	0	3,284,612	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,837,830		2,837,830	0	2,837,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,429,731		4,429,731	0	4,429,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,347,728		6,347,728	0	6,347,728	73.00
74.00	07400	RENAL DIALYSIS	217,661		217,661	0	217,661	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	223,218		223,218	0	223,218	76.01
76.03	03951	WOUND CARE	678,205		678,205	0	678,205	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,869,532		4,869,532	0	4,869,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,924,094		1,924,094		1,924,094	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	65,229,035	0	65,229,035	0	65,229,035	200.00
201.00		Less Observation Beds	1,924,094		1,924,094		1,924,094	201.00
202.00		Total (see instructions)	63,304,941	0	63,304,941	0	63,304,941	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/22/2016 3:18 pm

Title XVIII | Hospital | PPS

		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	30,547,601		30,547,601			30.00
31.00	03100	INTENSIVE CARE UNIT	5,903,796		5,903,796			31.00
43.00	04300	NURSERY	3,092,637		3,092,637			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,773,020	45,111,317	75,884,337	0.107073	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,259,870	36,521	4,296,391	0.541650	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,448,515	5,939,418	13,387,933	0.020933	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,014,018	11,558,445	14,572,463	0.313188	0.000000	54.00
54.01	05401	ULTRASOUND	1,353,836	3,851,397	5,205,233	0.098264	0.000000	54.01
56.00	05600	RADIOISOTOPE	5,465,740	12,467,295	17,933,035	0.045514	0.000000	56.00
57.00	05700	CT SCAN	8,262,733	25,123,742	33,386,475	0.018613	0.000000	57.00
58.00	05800	MRI	1,190,154	5,805,017	6,995,171	0.039958	0.000000	58.00
60.00	06000	LABORATORY	31,426,207	45,619,481	77,045,688	0.052097	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,578,943	3,206,817	4,785,760	0.168099	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	8,591,637	2,315,319	10,906,956	0.098768	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,780,168	3,724,076	7,504,244	0.208836	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,391,811	496,452	1,888,263	0.106863	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	653,522	130,214	783,736	0.189801	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	38,017,851	29,205,148	67,222,999	0.048861	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,759,836	3,179,891	10,939,727	0.259406	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,762,353	10,252,793	36,015,146	0.122996	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,215,225	26,661,869	47,877,094	0.132584	0.000000	73.00
74.00	07400	RENAL DIALYSIS	921,495	60,786	982,281	0.221587	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	2,124,945	2,124,945	0.105046	0.000000	76.01
76.03	03951	WOUND CARE	14,617	1,631,457	1,646,074	0.412014	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,913,767	42,581,942	53,495,709	0.091027	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,823,354	4,853,387	6,676,741	0.288179	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	255,162,706	285,937,729	541,100,435			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	255,162,706	285,937,729	541,100,435			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/22/2016 3:18 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.107073		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.541650		52.00
53.00	05300	ANESTHESIOLOGY	0.020933		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313188		54.00
54.01	05401	ULTRASOUND	0.098264		54.01
56.00	05600	RADIOISOTOPE	0.045514		56.00
57.00	05700	CT SCAN	0.018613		57.00
58.00	05800	MRI	0.039958		58.00
60.00	06000	LABORATORY	0.052097		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.168099		62.00
65.00	06500	RESPIRATORY THERAPY	0.098768		65.00
66.00	06600	PHYSICAL THERAPY	0.208836		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.106863		67.00
68.00	06800	SPEECH PATHOLOGY	0.189801		68.00
69.00	06900	ELECTROCARDIOLOGY	0.048861		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259406		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.122996		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.132584		73.00
74.00	07400	RENAL DIALYSIS	0.221587		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.105046		76.01
76.03	03951	WOUND CARE	0.412014		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.091027		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.288179		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/22/2016 3:18 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,545,703		10,545,703	0	10,545,703	30.00
31.00	03100	INTENSIVE CARE UNIT	3,530,664		3,530,664	0	3,530,664	31.00
43.00	04300	NURSERY	1,001,669		1,001,669	0	1,001,669	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,125,158		8,125,158	0	8,125,158	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,327,139		2,327,139	0	2,327,139	52.00
53.00	05300	ANESTHESIOLOGY	280,247		280,247	0	280,247	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,563,922		4,563,922	0	4,563,922	54.00
54.01	05401	ULTRASOUND	511,485		511,485	0	511,485	54.01
56.00	05600	RADIOISOTOPE	816,201		816,201	0	816,201	56.00
57.00	05700	CT SCAN	621,415		621,415	0	621,415	57.00
58.00	05800	MRI	279,511		279,511	0	279,511	58.00
60.00	06000	LABORATORY	4,013,872		4,013,872	0	4,013,872	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	804,482		804,482	0	804,482	62.00
65.00	06500	RESPIRATORY THERAPY	1,077,262	0	1,077,262	0	1,077,262	65.00
66.00	06600	PHYSICAL THERAPY	1,567,154	0	1,567,154	0	1,567,154	66.00
67.00	06700	OCCUPATIONAL THERAPY	201,786	0	201,786	0	201,786	67.00
68.00	06800	SPEECH PATHOLOGY	148,754	0	148,754	0	148,754	68.00
69.00	06900	ELECTROCARDIOLOGY	3,284,612		3,284,612	0	3,284,612	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,837,830		2,837,830	0	2,837,830	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,429,731		4,429,731	0	4,429,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,347,728		6,347,728	0	6,347,728	73.00
74.00	07400	RENAL DIALYSIS	217,661		217,661	0	217,661	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	223,218		223,218	0	223,218	76.01
76.03	03951	WOUND CARE	678,205		678,205	0	678,205	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	4,869,532		4,869,532	0	4,869,532	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,924,094		1,924,094		1,924,094	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
200.00		Subtotal (see instructions)	65,229,035	0	65,229,035	0	65,229,035	200.00
201.00		Less Observation Beds	1,924,094		1,924,094		1,924,094	201.00
202.00		Total (see instructions)	63,304,941	0	63,304,941	0	63,304,941	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/22/2016 3:18 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	30,547,601		30,547,601			30.00
31.00	03100	INTENSIVE CARE UNIT	5,903,796		5,903,796			31.00
43.00	04300	NURSERY	3,092,637		3,092,637			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,773,020	45,111,317	75,884,337	0.107073	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,259,870	36,521	4,296,391	0.541650	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	7,448,515	5,939,418	13,387,933	0.020933	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,014,018	11,558,445	14,572,463	0.313188	0.000000	54.00
54.01	05401	ULTRASOUND	1,353,836	3,851,397	5,205,233	0.098264	0.000000	54.01
56.00	05600	RADIOISOTOPE	5,465,740	12,467,295	17,933,035	0.045514	0.000000	56.00
57.00	05700	CT SCAN	8,262,733	25,123,742	33,386,475	0.018613	0.000000	57.00
58.00	05800	MRI	1,190,154	5,805,017	6,995,171	0.039958	0.000000	58.00
60.00	06000	LABORATORY	31,426,207	45,619,481	77,045,688	0.052097	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,578,943	3,206,817	4,785,760	0.168099	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	8,591,637	2,315,319	10,906,956	0.098768	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,780,168	3,724,076	7,504,244	0.208836	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,391,811	496,452	1,888,263	0.106863	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	653,522	130,214	783,736	0.189801	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	38,017,851	29,205,148	67,222,999	0.048861	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,759,836	3,179,891	10,939,727	0.259406	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,762,353	10,252,793	36,015,146	0.122996	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,215,225	26,661,869	47,877,094	0.132584	0.000000	73.00
74.00	07400	RENAL DIALYSIS	921,495	60,786	982,281	0.221587	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	2,124,945	2,124,945	0.105046	0.000000	76.01
76.03	03951	WOUND CARE	14,617	1,631,457	1,646,074	0.412014	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,913,767	42,581,942	53,495,709	0.091027	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,823,354	4,853,387	6,676,741	0.288179	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
200.00		Subtotal (see instructions)	255,162,706	285,937,729	541,100,435			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	255,162,706	285,937,729	541,100,435			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet C Part I Date/Time Prepared: 9/22/2016 3:18 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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.03	03951	WOUND CARE	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part I Date/Time Prepared: 9/22/2016 3:18 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	1,864,924	0	1,864,924	12,025	155.09	30.00
31.00	INTENSIVE CARE UNIT	606,113		606,113	1,250	484.89	31.00
43.00	NURSERY	111,377		111,377	1,675	66.49	43.00
200.00	Total (lines 30-199)	2,582,414		2,582,414	14,950		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	4,504	698,525		30.00
31.00	INTENSIVE CARE UNIT	667	323,422		31.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30-199)	5,171	1,021,947		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part II Date/Time Prepared: 9/22/2016 3:18 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	1,068,017	75,884,337	0.014074	11,137,539	156,750	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	263,467	4,296,391	0.061323	15,382	943	52.00
53.00	05300	ANESTHESIOLOGY	33,646	13,387,933	0.002513	2,080,312	5,228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	424,256	14,572,463	0.029114	1,574,279	45,834	54.00
54.01	05401	ULTRASOUND	101,529	5,205,233	0.019505	710,011	13,849	54.01
56.00	05600	RADIOISOTOPE	49,290	17,933,035	0.002749	2,717,512	7,470	56.00
57.00	05700	CT SCAN	75,391	33,386,475	0.002258	4,268,572	9,638	57.00
58.00	05800	MRI	62,050	6,995,171	0.008870	574,373	5,095	58.00
60.00	06000	LABORATORY	298,147	77,045,688	0.003870	15,351,387	59,410	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,394	4,785,760	0.004679	863,110	4,038	62.00
65.00	06500	RESPIRATORY THERAPY	79,899	10,906,956	0.007326	4,866,052	35,649	65.00
66.00	06600	PHYSICAL THERAPY	306,353	7,504,244	0.040824	2,278,630	93,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,770	1,888,263	0.006233	762,021	4,750	67.00
68.00	06800	SPEECH PATHOLOGY	6,871	783,736	0.008767	89,034	781	68.00
69.00	06900	ELECTROCARDIOLOGY	275,615	67,222,999	0.004100	19,749,496	80,973	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	57,912	10,939,727	0.005294	4,106,509	21,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,047	36,015,146	0.002667	11,123,845	29,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	189,242	47,877,094	0.003953	9,934,542	39,271	73.00
74.00	07400	RENAL DIALYSIS	16,936	982,281	0.017242	556,730	9,599	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	103,112	2,124,945	0.048525	0	0	76.01
76.03	03951	WOUND CARE	134,537	1,646,074	0.081732	12,368	1,011	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	541,547	53,495,709	0.010123	5,438,245	55,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	340,261	6,676,741	0.050962	882,677	44,983	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	4,558,289	501,556,401		99,092,626	724,753	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part III Date/Time Prepared: 9/22/2016 3:18 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
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,025	0.00	4,504	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,250	0.00	667	0		31.00
43.00	04300	NURSERY	1,675	0.00	0	0		43.00
200.00		Total (lines 30-199)	14,950		5,171	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/22/2016 3:18 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/22/2016 3:18 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	75,884,337	0.000000	0.000000	11,137,539	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,296,391	0.000000	0.000000	15,382	52.00
53.00	05300	ANESTHESIOLOGY	0	13,387,933	0.000000	0.000000	2,080,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,572,463	0.000000	0.000000	1,574,279	54.00
54.01	05401	ULTRASOUND	0	5,205,233	0.000000	0.000000	710,011	54.01
56.00	05600	RADIOISOTOPE	0	17,933,035	0.000000	0.000000	2,717,512	56.00
57.00	05700	CT SCAN	0	33,386,475	0.000000	0.000000	4,268,572	57.00
58.00	05800	MRI	0	6,995,171	0.000000	0.000000	574,373	58.00
60.00	06000	LABORATORY	0	77,045,688	0.000000	0.000000	15,351,387	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,785,760	0.000000	0.000000	863,110	62.00
65.00	06500	RESPIRATORY THERAPY	0	10,906,956	0.000000	0.000000	4,866,052	65.00
66.00	06600	PHYSICAL THERAPY	0	7,504,244	0.000000	0.000000	2,278,630	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,888,263	0.000000	0.000000	762,021	67.00
68.00	06800	SPEECH PATHOLOGY	0	783,736	0.000000	0.000000	89,034	68.00
69.00	06900	ELECTROCARDIOLOGY	0	67,222,999	0.000000	0.000000	19,749,496	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,939,727	0.000000	0.000000	4,106,509	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	36,015,146	0.000000	0.000000	11,123,845	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	47,877,094	0.000000	0.000000	9,934,542	73.00
74.00	07400	RENAL DIALYSIS	0	982,281	0.000000	0.000000	556,730	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	2,124,945	0.000000	0.000000	0	76.01
76.03	03951	WOUND CARE	0	1,646,074	0.000000	0.000000	12,368	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	53,495,709	0.000000	0.000000	5,438,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,676,741	0.000000	0.000000	882,677	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	501,556,401			99,092,626	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part IV Date/Time Prepared: 9/22/2016 3:18 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	9,814,561	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,358,864	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,372,321	0		54.00
54.01	05401	ULTRASOUND	0	1,284,065	0		54.01
56.00	05600	RADIOISOTOPE	0	3,778,994	0		56.00
57.00	05700	CT SCAN	0	7,254,576	0		57.00
58.00	05800	MRI	0	1,842,866	0		58.00
60.00	06000	LABORATORY	0	7,945,312	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,421,117	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,050,349	0		65.00
66.00	06600	PHYSICAL THERAPY	0	26,951	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,740	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	941	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,555,781	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	904,930	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,007,034	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,186,164	0		73.00
74.00	07400	RENAL DIALYSIS	0	3,275	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	726,065	0		76.01
76.03	03951	WOUND CARE	0	409,287	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	8,219,084	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,449,470	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	0	77,628,747	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/22/2016 3:18 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	0.107073	9,814,561	0	0	1,050,874	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.541650	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020933	1,358,864	0	0	28,445	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313188	3,372,321	0	0	1,056,170	54.00
54.01	05401	ULTRASOUND	0.098264	1,284,065	0	0	126,177	54.01
56.00	05600	RADIOISOTOPE	0.045514	3,778,994	0	0	171,997	56.00
57.00	05700	CT SCAN	0.018613	7,254,576	0	0	135,029	57.00
58.00	05800	MRI	0.039958	1,842,866	0	0	73,637	58.00
60.00	06000	LABORATORY	0.052097	7,945,312	0	0	413,927	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.168099	2,421,117	0	0	406,987	62.00
65.00	06500	RESPIRATORY THERAPY	0.098768	1,050,349	0	0	103,741	65.00
66.00	06600	PHYSICAL THERAPY	0.208836	26,951	0	0	5,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.106863	16,740	0	0	1,789	67.00
68.00	06800	SPEECH PATHOLOGY	0.189801	941	0	0	179	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048861	12,555,781	0	0	613,488	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259406	904,930	0	0	234,744	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.122996	4,007,034	0	0	492,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.132584	9,186,164	0	38,705	1,217,938	73.00
74.00	07400	RENAL DIALYSIS	0.221587	3,275	0	0	726	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.105046	726,065	0	0	76,270	76.01
76.03	03951	WOUND CARE	0.412014	409,287	0	0	168,632	76.03
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.091027	8,219,084	0	0	748,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.288179	1,449,470	0	0	417,707	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		77,628,747	0	38,705	7,545,093	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		77,628,747	0	38,705	7,545,093	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D Part V Date/Time Prepared: 9/22/2016 3:18 pm

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		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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,132		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	5,132		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	5,132		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/22/2016 3:18 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)	12,025	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,025	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)	9,831	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,504	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)	10,545,703	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)	10,545,703	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)	10,545,703	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)	876.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,949,918	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)	3,949,918	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/22/2016 3:18 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,530,664	1,250	2,824.53	667	1,883,962	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	9,626,398	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,460,278	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,021,947	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	724,753	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,746,700	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,713,578	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,194	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	876.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,924,094	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-1 | Date/Time Prepared: 9/22/2016 3:18 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	1,864,924	10,545,703	0.176842	1,924,094	340,261	90.00
91.00	Nursing School cost	0	10,545,703	0.000000	1,924,094	0	91.00
92.00	Allied health cost	0	10,545,703	0.000000	1,924,094	0	92.00
93.00	All other Medical Education	0	10,545,703	0.000000	1,924,094	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet D-3 | Date/Time Prepared: 9/22/2016 3:18 pm

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		14,827,429		30.00
31.00	03100	INTENSIVE CARE UNIT		3,138,409		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.107073	11,137,539	1,192,530	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.541650	15,382	8,332	52.00
53.00	05300	ANESTHESIOLOGY	0.020933	2,080,312	43,547	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.313188	1,574,279	493,045	54.00
54.01	05401	ULTRASOUND	0.098264	710,011	69,769	54.01
56.00	05600	RADIOISOTOPE	0.045514	2,717,512	123,685	56.00
57.00	05700	CT SCAN	0.018613	4,268,572	79,451	57.00
58.00	05800	MRI	0.039958	574,373	22,951	58.00
60.00	06000	LABORATORY	0.052097	15,351,387	799,761	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.168099	863,110	145,088	62.00
65.00	06500	RESPIRATORY THERAPY	0.098768	4,866,052	480,610	65.00
66.00	06600	PHYSICAL THERAPY	0.208836	2,278,630	475,860	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.106863	762,021	81,432	67.00
68.00	06800	SPEECH PATHOLOGY	0.189801	89,034	16,899	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048861	19,749,496	964,980	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259406	4,106,509	1,065,253	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.122996	11,123,845	1,368,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.132584	9,934,542	1,317,161	73.00
74.00	07400	RENAL DIALYSIS	0.221587	556,730	123,364	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.105046	0	0	76.01
76.03	03951	WOUND CARE	0.412014	12,368	5,096	76.03
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.091027	5,438,245	495,027	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.288179	882,677	254,369	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		99,092,626	9,626,398	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)		99,092,626		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/22/2016 3:18 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)	4,109,121	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,752,770	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)	216,325	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	1,337,315	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	92.01	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)	6.71	30.00
31.00	Percentage of Medicaid patient days (see instructions)	32.49	31.00
32.00	Sum of lines 30 and 31	39.20	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.00	33.00
34.00	Disproportionate share adjustment (see instructions)	295,857	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/22/2016 3:18 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)	7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000156449	0.000151731	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,196,470	972,012	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	501,534	565,679	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,067,213		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)	11,441,286		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)	11,441,286	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	827,150	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)	12,268,436	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	12,268,436	61.00
62.00	Deductibles billed to program beneficiaries	1,222,928	62.00
63.00	Coinsurance billed to program beneficiaries	15,897	63.00
64.00	Allowable bad debts (see instructions)	502,041	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	326,327	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	379,252	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	11,355,938	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	1,105	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)	7,923	70.93
70.94	HRR adjustment amount (see instructions)	-112,155	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part A Date/Time Prepared: 9/22/2016 3:18 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,252,811	71.00
71.01	Sequestration adjustment (see instructions)		225,056	71.01
72.00	Interim payments		10,625,050	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)		402,705	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		803,013	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)	1.0000803043	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)	0.9927	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet E Part B Date/Time Prepared: 9/22/2016 3:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,132	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,545,093	2.00
3.00	PPS payments	5,879,187	3.00
4.00	Outlier payment (see instructions)	128,769	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)	5,132	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	38,705	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)	38,705	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)	38,705	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	33,573	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)	5,132	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)	6,007,956	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)	1,241,361	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)	4,771,727	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)	4,771,727	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	4,771,727	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)	502,990	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	326,944	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	433,100	36.00
37.00	Subtotal (see instructions)	5,098,671	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,098,671	40.00
40.01	Sequestration adjustment (see instructions)	101,973	40.01
41.00	Interim payments	4,790,022	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	206,676	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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 9/22/2016 3:18 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		10,625,050		4,790,022	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,625,050		4,790,022	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		402,705		206,676	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,027,755		4,996,698	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140184 | Component CCN: 14U184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 9/22/2016 3:18 pm

Title XVIII | Swing Beds - SNF | PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet E-1 Part II Date/Time Prepared: 9/22/2016 3:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	3,989	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	5,171	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	731	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	11,081	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	541,100,435	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	492,755	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)	684,501	8.00
9.00	Sequestration adjustment amount (see instructions)	13,690	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	670,811	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	669,849	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)	962	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 140184 Component CCN: 14U184	Period: From 05/01/2015 To 04/30/2016	Worksheet E-2 Date/Time Prepared: 9/22/2016 3:18 pm
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G | Date/Time Prepared: 9/22/2016 3:18 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	-219,002	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	21,503,992	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,245,125	0	0	0	6.00
7.00	Inventory	2,982,736	0	0	0	7.00
8.00	Prepaid expenses	1,163,079	0	0	0	8.00
9.00	Other current assets	657,327	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)	24,843,007	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,393,860	0	0	0	12.00
13.00	Land improvements	562,648	0	0	0	13.00
14.00	Accumulated depreciation	-386,411	0	0	0	14.00
15.00	Buildings	46,989,565	0	0	0	15.00
16.00	Accumulated depreciation	-11,931,955	0	0	0	16.00
17.00	Leasehold improvements	4,128,311	0	0	0	17.00
18.00	Accumulated depreciation	-2,143,936	0	0	0	18.00
19.00	Fixed equipment	2,301,340	0	0	0	19.00
20.00	Accumulated depreciation	-1,603,809	0	0	0	20.00
21.00	Automobiles and trucks	2,994	0	0	0	21.00
22.00	Accumulated depreciation	-2,994	0	0	0	22.00
23.00	Major movable equipment	19,056,433	0	0	0	23.00
24.00	Accumulated depreciation	-13,191,489	0	0	0	24.00
25.00	Minor equipment depreciable	5,993,693	0	0	0	25.00
26.00	Accumulated depreciation	-4,719,000	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)	46,449,250	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	3,538,369	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,538,369	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	74,830,626	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,853,369	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,144,726	0	0	0	38.00
39.00	Payroll taxes payable	222,028	0	0	0	39.00
40.00	Notes and loans payable (short term)	15,000	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	-321,640,894	0	0	0	43.00
44.00	Other current liabilities	1,467,993	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-313,937,778	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,750	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)	18,750	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-313,919,028	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	388,749,654				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)	388,749,654	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	74,830,626	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-1 | Date/Time Prepared: 9/22/2016 3:18 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		348,537,442		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		40,212,206				2.00
3.00	Total (sum of line 1 and line 2)		388,749,648		0		3.00
4.00	ROUNDING	6		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)		6		0		10.00
11.00	Subtotal (line 3 plus line 10)		388,749,654		0		11.00
12.00		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)		388,749,654		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	ROUNDING		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			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: 140184 | Period: From 05/01/2015 To 04/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/22/2016 3:18 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	33,640,238		33,640,238	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)	33,640,238		33,640,238	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,903,796		5,903,796	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,903,796		5,903,796	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,544,034		39,544,034	17.00
18.00	Ancillary services	202,881,551	238,502,400	441,383,951	18.00
19.00	Outpatient services	12,737,121	47,435,329	60,172,450	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CRNA CHARGES	0	2,708,355	2,708,355	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	255,162,706	288,646,084	543,808,790	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		65,520,880		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)		65,520,880		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet G-3 Date/Time Prepared: 9/22/2016 3:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	543,808,790	1.00
2.00	Less contractual allowances and discounts on patients' accounts	439,078,192	2.00
3.00	Net patient revenues (line 1 minus line 2)	104,730,598	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	65,520,880	4.00
5.00	Net income from service to patients (line 3 minus line 4)	39,209,718	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 REVENUE	1,002,488	24.00
25.00	Total other income (sum of lines 6-24)	1,002,488	25.00
26.00	Total (line 5 plus line 25)	40,212,206	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)	40,212,206	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140184	Period: From 05/01/2015 To 04/30/2016	Worksheet L Parts I-III Date/Time Prepared: 9/22/2016 3:18 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	777,841	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	49,309	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)	30.65	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)	827,150	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