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: 140275	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 11/21/2016 11:22 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/21/2016 Time: 11:22 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. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GENESIS MEDICAL CENTER - SILVIS (140275) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	117,451	13,962	349,093	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
200.00	Total	0	117,451	13,962	349,093	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2016 11:20 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 801 HOSPITAL ROAD	PO Box:			1.00
2.00	City: SILVIS	State: IL	Zip Code: 61282-	County: ROCK ISLAND	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	GENESIS MEDICAL CENTER - SILVIS	140275	19340	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	ILLINI RESTORATIVE CARE CENTER	145703	19340		09/03/1991	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2015	06/30/2016	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	2,427	450	0	118	194	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 11:20 am

		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	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 11/21/2016 11:20 am

		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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 11:20 am

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	0	0	206,562	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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 11:20 am

		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	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WPS	Contractor's Number: 05001	141.00
142.00	Street: 1227 E. RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140275	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 11/21/2016 11:20 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2015	06/30/2016	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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II | Date/Time Prepared: 11/21/2016 11:20 am

		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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/29/2016	Y	09/29/2016	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 11/21/2016 11:20 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	Y		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	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.	MARTIN	ORWITZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175	ORWITZM@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 140275	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 11/21/2016 11:20 am

		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.	DIRECTOR, REIMBURSEMENT		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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 11:20 am

	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	138	50,508	4,621.00	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)		138	50,508	4,621.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,562	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)		145	53,070	4,621.00	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	44.00	92	33,672		0	19.00
20.00	NURSING FACILITY	45.00	28	10,248		0	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)		265				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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 11:20 am

	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)	4,645	489	11,957			1.00
2.00	HMO and other (see instructions)	1,985	2,460				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)	4,645	489	11,957			7.00
8.00	INTENSIVE CARE UNIT	425	52	1,045			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		188	736			13.00
14.00	Total (see instructions)	5,070	729	13,738	0.00	429.14	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	5,693	5,384	25,638	0.00	73.02	19.00
20.00	NURSING FACILITY		0	8,954	0.00	9.84	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	512.00	27.00
28.00	Observation Bed Days		16	1,832			28.00
29.00	Ambulance Trips	3,482					29.00
30.00	Employee discount days (see instruction)			126			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 11/21/2016 11:20 am

	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	1,526	861	4,100	1.00
2.00	HMO and other (see instructions)			562	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	1,526	861	4,100	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	0.00					19.00
20.00	NURSING FACILITY	0.00					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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/21/2016 11:20 am

		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	27,525,312	0	27,525,312	854,488.00	32.21	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	2,927,342	-3,880	2,923,462	150,014.00	19.49	9.00
10.00	Excluded area salaries (see instructions)		3,167,235	21,578	3,188,813	164,913.00	19.34	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,434,884	0	1,434,884	18,992.00	75.55	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		334,133	0	334,133	2,798.00	119.42	13.00
14.00	Home office salaries & wage-related costs		7,970,047	0	7,970,047	171,316.00	46.52	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)		5,349,746	0	5,349,746			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,202,312	0	1,202,312			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	45,355	0	45,355	2,002.00	22.65	26.00
27.00	Administrative & General	5.00	832,281	0	832,281	17,801.00	46.75	27.00
28.00	Administrative & General under contract (see inst.)		230,946	0	230,946	2,418.00	95.51	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	497,625	0	497,625	25,242.00	19.71	30.00
31.00	Laundry & Linen Service	8.00	48,318	-17,698	30,620	2,355.00	13.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		609,407	0	609,407	26,244.00	23.22	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		118,131	0	118,131	6,049.00	19.53	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	629,421	0	629,421	17,649.00	35.66	38.00
39.00	Central Services and Supply	14.00	105,205	0	105,205	7,331.00	14.35	39.00
40.00	Pharmacy	15.00	1,576,330	0	1,576,330	37,568.00	41.96	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 11/21/2016 11:20 am

		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	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 11/21/2016 11:20 am

		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)		28,483,796	0	28,483,796	889,199.00	32.03	1.00
2.00	Excluded area salaries (see instructions)		6,094,577	17,698	6,112,275	314,927.00	19.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)		22,389,219	-17,698	22,371,521	574,272.00	38.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,739,064	0	9,739,064	193,106.00	50.43	4.00
5.00	Subtotal wage-related costs (see inst.)		5,349,746	0	5,349,746	0.00	23.91	5.00
6.00	Total (sum of lines 3 thru 5)		37,478,029	-17,698	37,460,331	767,378.00	48.82	6.00
7.00	Total overhead cost (see instructions)		4,693,019	-17,698	4,675,321	144,659.00	32.32	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part IV | Date/Time Prepared: 11/21/2016 11:20 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	91,864	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	295,589	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	375,072	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)	1,975,549	8.00
9.00	Prescription Drug Plan	520,931	9.00
10.00	Dental, Hearing and Vision Plan	168,750	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,725	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	94,030	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	835,634	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	1,999,220	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	47,709	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	53	22.00
23.00	Tuition Reimbursement	119,933	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,552,059	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 11/21/2016 11:20 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,665,830	0	1.00
2.00	Hospital	1,665,830	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	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-7 | Date/Time Prepared: 11/21/2016 11:20 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	578	0	578	12.00
13.00		RUB	562	0	562	13.00
14.00		RUA	1,129	0	1,129	14.00
15.00		RVC	919	0	919	15.00
16.00		RVB	547	0	547	16.00
17.00		RVA	1,406	0	1,406	17.00
18.00		RHC	150	0	150	18.00
19.00		RHB	34	0	34	19.00
20.00		RHA	209	0	209	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	22	0	22	22.00
23.00		RMA	18	0	18	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	7	0	7	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	12	0	12	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	11	0	11	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	3	0	3	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	2	0	2	41.00
42.00		LC1	19	0	19	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	19	0	19	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	5	0	5	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	14	0	14	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	20	0	20	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	1	0	1	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-7 | Date/Time Prepared: 11/21/2016 11:20 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	4	0	4	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	2	0	2	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		5,693	0	5,693	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	19340		201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	2,974,870	39.45	N	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	536	0.01	N	204.00
205.00	Training	359	0.00	N	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	7,541,648			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet S-10 | Date/Time Prepared: 11/21/2016 11:20 am

		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)	0.330119	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	15,867,646	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	47,790,323	6.00
7.00	Medicaid cost (line 1 times line 6)	15,776,494	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,978,202	0	2,978,202	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	983,161	0	983,161	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)	983,161	0	983,161	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)	4,017,315	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	264,930	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,752,385	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,238,734	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,221,895	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,221,895	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/21/2016 11:20 am

		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	NEW CAP REL COSTS-BLDG & FIXT		2,116,182	2,116,182	-39,782	2,076,400	1.00
1.01	00101	NEW CAP RELATED IRC		428,283	428,283	0	428,283	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,512,197	2,512,197	0	2,512,197	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	45,355	3,533,514	3,578,869	0	3,578,869	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	832,281	20,753,141	21,585,422	0	21,585,422	5.00
7.00	00700	OPERATION OF PLANT	497,625	2,239,278	2,736,903	0	2,736,903	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	48,318	59,473	107,791	-39,483	68,308	8.00
9.00	00900	HOUSEKEEPING	0	800,523	800,523	-60,553	739,970	9.00
10.00	01000	DIETARY	0	902,938	902,938	-234,040	668,898	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	629,421	62,080	691,501	0	691,501	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	105,205	192,667	297,872	0	297,872	14.00
15.00	01500	PHARMACY	1,576,330	252,446	1,828,776	0	1,828,776	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,770,872	2,423,362	8,194,234	-248,643	7,945,591	30.00
31.00	03100	INTENSIVE CARE UNIT	844,164	186,349	1,030,513	0	1,030,513	31.00
43.00	04300	NURSERY	0	0	0	248,643	248,643	43.00
44.00	04400	SKILLED NURSING FACILITY	2,927,342	2,103,687	5,031,029	-68,850	4,962,179	44.00
45.00	04500	NURSING FACILITY	332,716	34,419	367,135	106,603	473,738	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,541,593	1,188,198	2,729,791	0	2,729,791	50.00
53.00	05300	ANESTHESIOLOGY	0	375,460	375,460	0	375,460	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,033,721	469,870	1,503,591	0	1,503,591	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	60,967	185,432	246,399	0	246,399	55.00
57.00	05700	CT SCAN	199,820	112,712	312,532	0	312,532	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,620	19,912	116,532	0	116,532	58.00
59.00	05900	CARDIAC CATHETERIZATION	462,421	473,545	935,966	0	935,966	59.00
60.00	06000	LABORATORY	2,016,249	3,704,663	5,720,912	0	5,720,912	60.00
65.00	06500	RESPIRATORY THERAPY	1,011,698	311,116	1,322,814	0	1,322,814	65.00
66.00	06600	PHYSICAL THERAPY	1,976,462	453,332	2,429,794	0	2,429,794	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,196,096	4,196,096	-2,820,446	1,375,650	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,820,446	2,820,446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,069,363	4,069,363	0	4,069,363	73.00
76.00	03020	CARDIAC REHAB	335,927	122,096	458,023	0	458,023	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,750	18,531	90,281	0	90,281	90.00
90.01	09001	WOUND CENTER	170,950	262,334	433,284	0	433,284	90.01
91.00	09100	EMERGENCY	2,102,986	4,025,078	6,128,064	0	6,128,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,679,362	1,119,959	3,799,321	40,439	3,839,760	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,370,155	59,708,236	87,078,391	-295,666	86,782,725	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,231	43,231	11,099	54,330	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,714	658,325	683,039	4,371	687,410	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	44,674	44,674	192.01
194.00	07950	CROSSTOWN SQUARE	130,443	799,017	929,460	1,482	930,942	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	234,040	234,040	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	799	799	0	799	194.04
200.00		TOTAL (SUM OF LINES 118-199)	27,525,312	61,209,608	88,734,920	0	88,734,920	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-210,236	1,866,164		1.00
1.01	00101	NEW CAP RELATED IRC	-129,534	298,749		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	2,512,197		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0	0		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-827,005	2,751,864		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,742,556	13,842,866		5.00
7.00	00700	OPERATION OF PLANT	-45,289	2,691,614		7.00
7.01	00701	OPERATION OF PLANT IRC	0	0		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	-50,532	17,776		8.00
9.00	00900	HOUSEKEEPING	-49,162	690,808		9.00
10.00	01000	DIETARY	-118,398	550,500		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-221	691,280		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	367,185	665,057		14.00
15.00	01500	PHARMACY	-17,549	1,811,227		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,082,384	1,082,384		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,242,467	6,703,124		30.00
31.00	03100	INTENSIVE CARE UNIT	-11,538	1,018,975		31.00
43.00	04300	NURSERY	0	248,643		43.00
44.00	04400	SKILLED NURSING FACILITY	-93,489	4,868,690		44.00
45.00	04500	NURSING FACILITY	233	473,971		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-66,500	2,663,291		50.00
53.00	05300	ANESTHESIOLOGY	-337,266	38,194		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-169,099	1,334,492		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	246,399		55.00
57.00	05700	CT SCAN	0	312,532		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	116,532		58.00
59.00	05900	CARDIAC CATHETERIZATION	-5,621	930,345		59.00
60.00	06000	LABORATORY	-50,073	5,670,839		60.00
65.00	06500	RESPIRATORY THERAPY	-44,619	1,278,195		65.00
66.00	06600	PHYSICAL THERAPY	-164,483	2,265,311		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-13,323	1,362,327		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,820,446		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,069,363		73.00
76.00	03020	CARDIAC REHAB	-9,386	448,637		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-260	90,021		90.00
90.01	09001	WOUND CENTER	-30,210	403,074		90.01
91.00	09100	EMERGENCY	-3,325,436	2,802,628		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,039,717	2,800,043		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,344,167	72,438,558		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-119,527	-65,197		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-495,430	191,980		192.00
192.01	19201	NONREIMBURSABLE	0	44,674		192.01
194.00	07950	CROSSTOWN SQUARE	-82,787	848,155		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	234,040		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0		194.03
194.04	07951	OUTREACH	-6,568	-5,769		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-15,048,479	73,686,441		200.00

RECLASSIFICATIONS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/21/2016 11:20 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - POB DEPRECIATION					
1.00	NONREIMBURSABLE	192.01	0	39,782		1.00
	0		0	39,782		
	B - NURSING HOME OVERHEAD COSTS					
1.00	NURSING FACILITY	45.00	19,396	84,069		1.00
	0		19,396	84,069		
	C - NURSERY COSTS					
1.00	NURSERY	43.00	207,907	40,736		1.00
	0		207,907	40,736		
	D - CHARGEABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,820,446		1.00
	0		0	2,820,446		
	E - DIETARY COST AND EMPLOYEE MEALS					
1.00	NONALLOWABLE PHYSICIAN	194.02	0	234,040		1.00
	0		0	234,040		
	F - RECLASS HOUSEKEEPING COST					
1.00	AMBULANCE SERVICES	95.00	0	40,439		1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	11,099		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,123		3.00
4.00	NONREIMBURSABLE	192.01	0	4,892		4.00
	0		0	60,553		
	G - RECLASS LAUNDRY COST					
1.00	SKILLED NURSING FACILITY	44.00	15,516	19,099		1.00
2.00	NURSING FACILITY	45.00	1,407	1,731		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	111	137		3.00
4.00	CROSSTOWN SQUARE	194.00	664	818		4.00
	0		17,698	21,785		
500.00	Grand Total: Increases		245,001	3,301,411		500.00

RECLASSIFICATIONS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-6 | Date/Time Prepared: 11/21/2016 11:20 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - POB DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	39,782	9		1.00
	0		0	39,782			
	B - NURSING HOME OVERHEAD COSTS						
1.00	SKILLED NURSING FACILITY	44.00	19,396	84,069	0		1.00
	0		19,396	84,069			
	C - NURSERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	207,907	40,736	0		1.00
	0		207,907	40,736			
	D - CHARGEABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,820,446	0		1.00
	0		0	2,820,446			
	E - DIETARY COST AND EMPLOYEE MEALS						
1.00	DIETARY	10.00	0	234,040	0		1.00
	0		0	234,040			
	F - RECLASS HOUSEKEEPING COST						
1.00	HOUSEKEEPING	9.00	0	60,553	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		0	60,553			
	G - RECLASS LAUNDRY COST						
1.00	LAUNDRY & LINEN SERVICE	8.00	17,698	21,785	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		17,698	21,785			
500.00	Grand Total: Decreases		245,001	3,301,411			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part I | Date/Time Prepared: 11/21/2016 11:20 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,374,122	0	0	0	0	1.00
2.00	Land Improvements	4,952,083	58,132	0	58,132	0	2.00
3.00	Buildings and Fixtures	60,242,158	770,952	0	770,952	0	3.00
4.00	Building Improvements	2,090,594	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	47,071,269	1,384,986	0	1,384,986	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	116,730,226	2,214,070	0	2,214,070	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	116,730,226	2,214,070	0	2,214,070	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,374,122	0	1.00
2.00	Land Improvements	5,010,215	0	2.00
3.00	Buildings and Fixtures	61,013,110	0	3.00
4.00	Building Improvements	2,090,594	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	48,456,255	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	118,944,296	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	118,944,296	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part II Date/Time Prepared: 11/21/2016 11:20 am

	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	NEW CAP REL COSTS-BLDG & FIXT	2,116,182	0	0	0	0	1.00
1.01	NEW CAP RELATED IRC	428,283	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,512,197	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	5,056,662	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	NEW CAP REL COSTS-BLDG & FIXT	0	2,116,182		1.00
1.01	NEW CAP RELATED IRC	0	428,283		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,512,197		2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0		2.01
3.00	Total (sum of lines 1-2)	0	5,056,662		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-7 Part III Date/Time Prepared: 11/21/2016 11:20 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	68,113,918	0	68,113,918	0.584317	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	48,456,255	0	48,456,255	0.415683	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	116,570,173	0	116,570,173	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,076,400	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	428,283	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,512,197	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	5,016,880	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-210,236	0	0	0	1,866,164	1.00
1.01	NEW CAP RELATED IRC	-129,534	0	0	0	298,749	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,512,197	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	-339,770	0	0	0	4,677,110	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/21/2016 11:20 am

	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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP RELATED IRC (chapter 2)		0	NEW CAP RELATED IRC	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP IRC (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,050,588			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	-1,155,117			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP RELATED IRC		0	NEW CAP RELATED IRC	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP IRC		0	CAP REL COSTS-MVBLE EQUIP IRC	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/21/2016 11:20 am

	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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADMINISTRATION - RENTAL INCOME -3RD	B	-36,948	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-89,274	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-1,320	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.03	ADMINISTRATION - DISCOUNTS EARNED	B	-6,717	ADMINISTRATIVE & GENERAL	5.00	0	35.03
35.05			0		0.00	0	35.05
35.07	ADMINISTRATION - INV INC - GENRAD IM	B	22,270	ADMINISTRATIVE & GENERAL	5.00	0	35.07
35.08	ADMINISTRATION - MISCELLANEOUS REVEN	B	-16,487	ADMINISTRATIVE & GENERAL	5.00	0	35.08
35.11	SWITCHBOARD - MISCELLANEOUS REVENUE	B	-770	ADMINISTRATIVE & GENERAL	5.00	0	35.11
35.13	INFORMATION TECHNOLOGY - MISCELLANEO	B	-7,070	ADMINISTRATIVE & GENERAL	5.00	0	35.13
35.14	MEDICAL STAFF - ILLINI - MISCELLANEO	B	-34,350	ADMINISTRATIVE & GENERAL	5.00	0	35.14
36.03	SECURITY - INTERCOMPANY REVENUE	B	-25,164	OPERATION OF PLANT	7.00	0	36.03
36.07	GROUNDS - INTERCOMPANY REVENUE	B	-2,989	OPERATION OF PLANT	7.00	0	36.07
36.08	LAUNDRY - INTERCOMPANY REVENUE	B	-50,532	LAUNDRY & LINEN SERVICE	8.00	0	36.08
36.09	NUTRITIONAL SERVICES - VENDING SALES	B	-4,282	DIETARY	10.00	9	36.09
36.10	NUTRITIONAL SERVICES - MISCELLANEOUS	B	-114,116	DIETARY	10.00	0	36.10
36.11	STERILE PROCESSING - MISCELLANEOUS R	B	-6,000	CENTRAL SERVICES & SUPPLY	14.00	0	36.11
36.13	PHARMACY - INTERCOMPANY REVENUE	B	-17,549	PHARMACY	15.00	0	36.13
36.14	BIRTH ASSOCIATES - MISCELLANEOUS REV	B	-1,905	ADULTS & PEDIATRICS	30.00	0	36.14
36.15	PEDIATRICS - MISCELLANEOUS REVENUE	B	-93	ADULTS & PEDIATRICS	30.00	0	36.15
36.18			0		0.00	0	36.18
36.20	GIC-MLI-GENRAD IL - OUTREACH REVENUE	B	-163,279	RADIOLOGY-DIAGNOSTIC	54.00	0	36.20
36.21	RADIOLOGY - INTERCOMPANY REVENUE	B	-5,820	RADIOLOGY-DIAGNOSTIC	54.00	0	36.21
37.00			0		0.00	0	37.00
37.06	CARDIAC CATH LAB - OUTREACH REVENUE	B	-5,621	CARDIAC CATHETERIZATION	59.00	0	37.06
37.07	LABORATORY - INTERCOMPANY REVENUE	B	-28,970	LABORATORY	60.00	0	37.07
37.09	PULMONARY SERVICES - INTERCOMPANY RE	B	-98	RESPIRATORY THERAPY	65.00	0	37.09
37.10	P.T. CLINIC -MOLINE HEALTHPLEX - INT	B	-96,045	PHYSICAL THERAPY	66.00	0	37.10
37.11	PHYSICAL THERAPY - MISCELLANEOUS REV	B	-1,825	PHYSICAL THERAPY	66.00	0	37.11
37.12	P.T. CLINIC -MOLINE HEALTHPLEX - MIS	B	-25	PHYSICAL THERAPY	66.00	0	37.12
37.14			0		0.00	0	37.14
38.00	DISTRIBUTION - MISCELLANEOUS REVENUE	B	-13,323	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	38.00
39.00	CARDIAC REHAB - MISCELLANEOUS REVENU	B	-9,386	CARDIAC REHAB	76.00	0	39.00
39.01	DIABETES CARE CENTER - MISCELLANEOUS	B	-260	CLINIC	90.00	0	39.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/21/2016 11:20 am

	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	
39.02	WOUND CENTER - MISCELLANEOUS REVENUE	B	-1	WOUND CENTER	90.01	0	39.02
39.03	TRAUMA - MISCELLANEOUS REVENUE	B	-26,851	EMERGENCY	91.00	0	39.03
39.04	AMBULANCE - CPE REVENUE	B	-21,480	AMBULANCE SERVICES	95.00	0	39.04
40.00	AMBULANCE - MISCELLANEOUS REVENUE	B	-652,815	AMBULANCE SERVICES	95.00	0	40.00
41.00	AMBULANCE OUTREACH - MISCELLANEOUS R	B	-365,377	AMBULANCE SERVICES	95.00	0	41.00
42.00	AUXILIARY - GIFT SHOP - MISCELLANEOU	B	-49,318	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	42.00
42.01	AUXILIARY - MISCELLANEOUS REVENUE	B	-50,786	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	42.01
43.00	PHYSICIAN OFFICE - RENTAL INCOME -3R	B	-74,187	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.00
43.02	2526 41ST ST. - MOLINE - RENTAL INCO	B	-32,830	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.02
43.03	GENESIS HEALTHPLEX-MOLINE - RENTAL I	B	-127,130	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.03
43.04	PHYSICIAN OFFICE - RENTAL INCOME - R	B	-150,341	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.04
43.06	2526 41ST ST. - MOLINE - RENTAL INCO	B	-110,942	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.06
43.07	ENVIRONMENTAL SVC - OUTREACH - OTHER	B	-6,568	OUTREACH	194.04	0	43.07
43.09	SHELTERED BEDS - OUTREACH REVENUE	B	233	NURSING FACILITY	45.00	0	43.09
43.10	PHYSICAL THERAPY - RENTAL INCOME - R	B	-55,644	PHYSICAL THERAPY	66.00	0	43.10
43.11	NURSING FLOOR - CS - MISCELLANEOUS R	B	-395	CROSSTOWN SQUARE	194.00	0	43.11
43.12	BEAUTY SHOP - CS - MISCELLANEOUS REV	B	-12,465	CROSSTOWN SQUARE	194.00	0	43.12
43.13	FOOD SERVICE - CS - MISCELLANEOUS RE	B	-2,256	CROSSTOWN SQUARE	194.00	0	43.13
43.14	SWITCHBOARD- CS - MISCELLANEOUS REVE	B	-10,338	CROSSTOWN SQUARE	194.00	0	43.14
43.15	NURSING FLOOR - IRC MEDICARE - MISCE	B	-430	SKILLED NURSING FACILITY	44.00	0	43.15
44.00	DISTRIBUTION - MISCELLANEOUS REVENUE	B	-600	CENTRAL SERVICES & SUPPLY	14.00	0	44.00
44.01	BEAUTY SHOP - IRC - MISCELLANEOUS RE	B	-19,423	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	44.01
44.02	INTEREST - INTEREST EXPENSE - 2010 B	A	-210,236	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	44.02
44.03			0		0.00	0	44.03
44.04	INTEREST- IRC - INTEREST EXPENSE - R	A	-129,534	NEW CAP RELATED IRC	1.01	11	44.04
44.05	INTEREST - CS - INTEREST EXPENSE - R	A	-47,910	CROSSTOWN SQUARE	194.00	0	44.05
44.06	NURSING FLOOR - IRC MEDICARE - CONTR	A	-42,526	SKILLED NURSING FACILITY	44.00	0	44.06
45.00	ENVIRONMENTAL SVCS - IRC - CONTRACT	A	-49,162	HOUSEKEEPING	9.00	0	45.00
45.01	ENVIRONMENTAL SVC - CS - CONTRACT FE	A	-1,370	CROSSTOWN SQUARE	194.00	0	45.01
45.02	SECURITY - IRC - CONTRACT FEES- ILLI	A	-17,136	OPERATION OF PLANT	7.00	0	45.02
45.03	SECURITY - CS - CONTRACT FEES- ILLIN	A	-8,028	CROSSTOWN SQUARE	194.00	0	45.03
45.04	ADMINISTRATION - PHYSICIAN PRACTICE	A	-2,072,529	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	PHYSICIAN SUPPORT SVCS	A	-122,690	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	MEDICAL STAFF - ILLINI - DONATIONS	A	-20,815	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	DISTRIBUTION - DONATED INVENTORY	A	-234	CENTRAL SERVICES & SUPPLY	14.00	0	45.07
45.08	ALCOHOL	A	-941	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	ADVERTISING & PROMOTIONS	A	-63,479	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	ADVERTISING & PROMOTIONS	A	-221	NURSING ADMINISTRATION	13.00	0	45.10
45.11	ADVERTISING & PROMOTIONS	A	-25	SKILLED NURSING FACILITY	44.00	0	45.11
45.12	ADVERTISING & PROMOTIONS	A	-115	RESPIRATORY THERAPY	65.00	0	45.12

ADJUSTMENTS TO EXPENSES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8 | Date/Time Prepared: 11/21/2016 11:20 am

	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	
45.13	ADVERTISING & PROMOTIONS	A	-10,944	PHYSICAL THERAPY	66.00	0	45.13
45.14	ADVERTISING & PROMOTIONS	A	-583	WOUND CENTER	90.01	0	45.14
45.15	ADVERTISING & PROMOTIONS	A	-25	CROSSTOWN SQUARE	194.00	0	45.15
45.16	ADMINISTRATION - PROVIDER TAX ASSESS	A	-2,582,068	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	NURSING ADMIN - IRC - PROVIDER TAX A	A	-50,508	SKILLED NURSING FACILITY	44.00	0	45.17
45.18	ADMINISTRATOR - IRC - PROVIDER TAX A	A	-96,798	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19	SELF INSURANCE	A	-827,005	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.19
45.20			0		0.00	0	45.20
45.21			0		0.00	0	45.21
45.22			0		0.00	0	45.22
45.23			0		0.00	0	45.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,048,479				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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 11/21/2016 11:20 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	GHS HOME OFFICE COSTS	11,058,322	13,669,842	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	GHS HOME OFFICE COSTS	374,019	0	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	GHS HOME OFFICE COSTS	1,082,384	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00		GHS HOME OFFICE COSTS	0	0	4.04
5.00	0		0	12,514,725	13,669,842	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	C		0.00	GENESIS HEALTH SYSTEM	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140275	Period: From 07/01/2015 To 06/30/2016	Worksheet A-8-1 Date/Time Prepared: 11/21/2016 11:20 am

	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	-2,611,520	0		1.00
2.00	0	9		2.00
3.00	0	0		3.00
4.00	374,019	0		4.00
4.01	1,082,384	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	-1,155,117			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 11/21/2016 11:20 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	179,261	1,050	178,211	211,500	1,753	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,240,469	1,240,469	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	11,538	11,538	0	0	0	3.00
4.00	50.00	OPERATING ROOM	66,500	66,500	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	337,266	337,266	0	0	0	5.00
6.00	60.00	LABORATORY	148,250	21,100	127,150	260,300	1,016	6.00
7.00	65.00	RESPIRATORY THERAPY	47,355	44,388	2,967	211,500	29	7.00
8.00	90.01	WOUND CENTER	29,626	29,626	0	0	0	8.00
9.00	91.00	EMERGENCY	3,311,600	3,298,550	13,050	211,500	128	9.00
10.00	95.00	AMBULANCE SERVICES	12,755	0	12,755	211,500	125	10.00
200.00			5,384,620	5,050,487	334,133		3,051	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	178,250	8,913	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	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	60.00	LABORATORY	127,147	6,357	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	2,949	147	0	0	0	7.00
8.00	90.01	WOUND CENTER	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	13,015	651	0	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	12,710	636	0	0	0	10.00
200.00			334,071	16,704	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	178,250	0	1,050		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,240,469		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,538		3.00
4.00	50.00	OPERATING ROOM	0	0	0	66,500		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	337,266		5.00
6.00	60.00	LABORATORY	0	127,147	3	21,103		6.00
7.00	65.00	RESPIRATORY THERAPY	0	2,949	18	44,406		7.00
8.00	90.01	WOUND CENTER	0	0	0	29,626		8.00
9.00	91.00	EMERGENCY	0	13,015	35	3,298,585		9.00
10.00	95.00	AMBULANCE SERVICES	0	12,710	45	45		10.00
200.00			0	334,071	101	5,050,588		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,866,164	1,866,164				1.00
1.01	00101	NEW CAP RELATED IRC	298,749	0	298,749			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,512,197			2,512,197		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC	0			0	0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,751,864	4,540	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,842,866	435,715	0	204,312	0	5.00
7.00	00700	OPERATION OF PLANT	2,691,614	176,142	0	81,849	0	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	12,783	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	17,776	19,407	1,032	0	0	8.00
9.00	00900	HOUSEKEEPING	690,808	8,852	2,257	5,321	0	9.00
10.00	01000	DIETARY	550,500	42,809	0	7,724	0	10.00
11.00	01100	CAFETERIA	0	23,768	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	691,280	6,323	0	5,207	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	665,057	54,215	0	29,635	0	14.00
15.00	01500	PHARMACY	1,811,227	37,613	0	105,149	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,082,384	22,309	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,949	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,703,124	348,685	0	226,398	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,018,975	30,318	0	45,459	0	31.00
43.00	04300	NURSERY	248,643	17,583	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,868,690	0	170,569	16,099	0	44.00
45.00	04500	NURSING FACILITY	473,971	0	82,176	9,498	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,663,291	130,568	0	317,420	0	50.00
53.00	05300	ANESTHESIOLOGY	38,194	0	0	62,831	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,334,492	71,806	0	259,623	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	246,399	0	0	0	0	55.00
57.00	05700	CT SCAN	312,532	0	0	152,993	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	116,532	1,475	0	6,350	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	930,345	19,520	0	225,515	0	59.00
60.00	06000	LABORATORY	5,670,839	121,465	0	151,108	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,278,195	22,795	0	92,474	0	65.00
66.00	06600	PHYSICAL THERAPY	2,265,311	27,448	23,019	28,199	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,362,327	0	0	70,865	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,820,446	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,069,363	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	448,637	70,525	0	12,685	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	90,021	0	0	0	0	90.00
90.01	09001	WOUND CENTER	403,074	15,345	0	5,172	0	90.01
91.00	09100	EMERGENCY	2,802,628	71,627	0	55,059	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,800,043	57,563	0	323,200	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,438,558	1,847,365	291,836	2,500,145	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-65,197	12,930	2,017	619	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	191,980	5,869	0	1,762	0	192.00
192.01	19201	NONREIMBURSABLE	44,674	0	4,896	9,671	0	192.01
194.00	07950	CROSSTOWN SQUARE	848,155	0	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	234,040	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	-5,769	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	73,686,441	1,866,164	298,749	2,512,197	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			4.00	4A	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,756,404					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	83,206	14,566,099	14,566,099			5.00
7.00	00700	OPERATION OF PLANT	49,750	2,999,355	738,303	3,737,658		7.00
7.01	00701	OPERATION OF PLANT IRC	0	12,783	3,147	0	15,930	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,061	41,276	10,160	58,039	57	8.00
9.00	00900	HOUSEKEEPING	0	707,238	174,089	26,474	126	9.00
10.00	01000	DIETARY	0	601,033	147,947	128,030	0	10.00
11.00	01100	CAFETERIA	0	23,768	5,851	71,082	0	11.00
13.00	01300	NURSING ADMINISTRATION	62,926	765,736	188,489	18,910	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,518	759,425	186,936	162,140	0	14.00
15.00	01500	PHARMACY	157,592	2,111,581	519,774	112,490	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,104,693	271,925	66,718	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,949	2,203	26,765	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	556,159	7,834,366	1,928,437	1,042,805	0	30.00
31.00	03100	INTENSIVE CARE UNIT	84,394	1,179,146	290,252	90,670	0	31.00
43.00	04300	NURSERY	20,785	287,011	70,649	52,584	0	43.00
44.00	04400	SKILLED NURSING FACILITY	296,148	5,351,506	1,317,295	0	9,502	44.00
45.00	04500	NURSING FACILITY	31,465	597,110	146,981	0	4,578	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	154,119	3,265,398	803,791	390,489	0	50.00
53.00	05300	ANESTHESIOLOGY	0	101,025	24,868	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,345	1,769,266	435,512	214,748	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,095	252,494	62,152	0	0	55.00
57.00	05700	CT SCAN	19,977	485,502	119,508	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,659	134,016	32,989	4,412	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	46,230	1,221,610	300,704	58,378	0	59.00
60.00	06000	LABORATORY	201,572	6,144,984	1,512,612	363,264	0	60.00
65.00	06500	RESPIRATORY THERAPY	101,143	1,494,607	367,903	68,173	0	65.00
66.00	06600	PHYSICAL THERAPY	197,595	2,541,572	625,618	82,088	1,282	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,433,192	352,786	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,820,446	694,264	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,069,363	1,001,690	0	0	73.00
76.00	03020	CARDIAC REHAB	33,584	565,431	139,183	210,918	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7,173	97,194	23,925	0	0	90.00
90.01	09001	WOUND CENTER	17,091	440,682	108,476	45,893	0	90.01
91.00	09100	EMERGENCY	210,244	3,139,558	772,815	214,215	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	271,196	3,452,002	849,724	172,153	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,735,027	72,379,417	14,230,958	3,681,438	15,545	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	914	-48,717	0	38,668	112	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,821	202,432	49,829	17,552	0	192.00
192.01	19201	NONREIMBURSABLE	403	59,644	14,682	0	273	192.01
194.00	07950	CROSSTOWN SQUARE	13,107	861,262	212,003	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	4,132	238,172	58,627	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	-5,769	0	0	0	194.04
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,756,404	73,686,441	14,566,099	3,737,658	15,930	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	109,532					8.00
9.00	00900	HOUSEKEEPING	0	907,927				9.00
10.00	01000	DIETARY	0	34,110	911,120			10.00
11.00	01100	CAFETERIA	0	18,938	727,224	846,863		11.00
13.00	01300	NURSING ADMINISTRATION	0	5,038	0	17,922	996,095	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	595	43,197	0	7,561	0	14.00
15.00	01500	PHARMACY	0	10,225	0	37,870	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,775	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,131	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,149	277,825	167,148	211,699	565,862	30.00
31.00	03100	INTENSIVE CARE UNIT	3,096	24,156	16,748	27,301	72,235	31.00
43.00	04300	NURSERY	1,222	14,009	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	33,575	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	2,450	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,439	104,034	0	53,118	128,498	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,057	57,213	0	39,854	88	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,880	0	55.00
57.00	05700	CT SCAN	2,917	0	0	6,872	30	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	524	1,176	0	2,736	8	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,273	15,553	0	8,669	12,867	59.00
60.00	06000	LABORATORY	18	57,162	0	89,735	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,228	18,163	0	39,437	91	65.00
66.00	06600	PHYSICAL THERAPY	1,067	26,088	0	65,254	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	26	38,159	0	11,656	25,902	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	3,029	0	90.00
90.01	09001	WOUND CENTER	0	12,227	0	6,789	15,278	90.01
91.00	09100	EMERGENCY	15,711	57,071	0	64,941	174,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	45,865	0	140,347	714	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	108,347	885,115	911,120	836,670	996,095	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,588	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,185	4,676	0	1,650	0	192.00
192.01	19201	NONREIMBURSABLE	0	5,548	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	8,543	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
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)	109,532	907,927	911,120	846,863	996,095	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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	1,159,854					14.00
15.00	01500	PHARMACY	6,606	2,798,546				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,461,111			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	45,048		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	68,465	0	113,385	27,080	12,261,221	30.00
31.00	03100	INTENSIVE CARE UNIT	13,608	0	24,281	989	1,742,482	31.00
43.00	04300	NURSERY	0	0	5,749	2,819	434,043	43.00
44.00	04400	SKILLED NURSING FACILITY	32,119	0	53,312	0	6,797,309	44.00
45.00	04500	NURSING FACILITY	1,715	0	6,751	0	759,585	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	117,468	0	112,401	14,160	5,003,796	50.00
53.00	05300	ANESTHESIOLOGY	4,608	0	19,979	0	150,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,208	0	74,081	0	2,602,027	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	31,085	0	17,714	0	365,325	55.00
57.00	05700	CT SCAN	9,997	0	119,503	0	744,329	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	468	0	24,877	0	201,206	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,986	0	65,557	0	1,700,597	59.00
60.00	06000	LABORATORY	9,658	0	236,115	0	8,413,548	60.00
65.00	06500	RESPIRATORY THERAPY	16,604	0	92,613	0	2,098,819	65.00
66.00	06600	PHYSICAL THERAPY	2,758	0	56,762	0	3,402,489	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	251,398	0	37,929	0	2,075,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	505,007	0	69,610	0	4,089,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,798,546	140,432	0	8,010,031	73.00
76.00	03020	CARDIAC REHAB	1,553	0	6,164	0	998,992	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	177	0	987	0	125,312	90.00
90.01	09001	WOUND CENTER	8,163	0	26,554	0	664,062	90.01
91.00	09100	EMERGENCY	39,342	0	156,355	0	4,634,530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	17,801	0	0	0	4,678,606	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,159,794	2,798,546	1,461,111	45,048	71,953,421	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	2,651	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	277,324	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	80,147	192.01
194.00	07950	CROSSTOWN SQUARE	56	0	0	0	1,081,864	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	296,799	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	4	0	0	0	-5,765	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,159,854	2,798,546	1,461,111	45,048	73,686,441	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part I | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP RELATED IRC				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT IRC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	12,261,221		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,742,482		31.00
43.00	04300	NURSERY	0	434,043		43.00
44.00	04400	SKILLED NURSING FACILITY	0	6,797,309		44.00
45.00	04500	NURSING FACILITY	0	759,585		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,003,796		50.00
53.00	05300	ANESTHESIOLOGY	0	150,480		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,602,027		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	365,325		55.00
57.00	05700	CT SCAN	0	744,329		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	201,206		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,700,597		59.00
60.00	06000	LABORATORY	0	8,413,548		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,098,819		65.00
66.00	06600	PHYSICAL THERAPY	0	3,402,489		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,075,305		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,089,327		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,010,031		73.00
76.00	03020	CARDIAC REHAB	0	998,992		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	125,312		90.00
90.01	09001	WOUND CENTER	0	664,062		90.01
91.00	09100	EMERGENCY	0	4,634,530		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	4,678,606		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	71,953,421		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,651		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	277,324		192.00
192.01	19201	NONREIMBURSABLE	0	80,147		192.01
194.00	07950	CROSSTOWN SQUARE	0	1,081,864		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	296,799		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0		194.03
194.04	07951	OUTREACH	0	-5,765		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	73,686,441		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,540	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	335,451	435,715	0	204,312	0	5.00
7.00	00700	OPERATION OF PLANT	92,041	176,142	0	81,849	0	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	12,783	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,407	1,032	0	0	8.00
9.00	00900	HOUSEKEEPING	2,433	8,852	2,257	5,321	0	9.00
10.00	01000	DIETARY	18,100	42,809	0	7,724	0	10.00
11.00	01100	CAFETERIA	0	23,768	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,938	6,323	0	5,207	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,610	54,215	0	29,635	0	14.00
15.00	01500	PHARMACY	81,347	37,613	0	105,149	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,309	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,949	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	67,948	348,685	0	226,398	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,367	30,318	0	45,459	0	31.00
43.00	04300	NURSERY	0	17,583	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	29,468	0	170,569	16,099	0	44.00
45.00	04500	NURSING FACILITY	0	0	82,176	9,498	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	90,071	130,568	0	317,420	0	50.00
53.00	05300	ANESTHESIOLOGY	7,941	0	0	62,831	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,730	71,806	0	259,623	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,385	0	0	0	0	55.00
57.00	05700	CT SCAN	18,699	0	0	152,993	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,900	1,475	0	6,350	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,445	19,520	0	225,515	0	59.00
60.00	06000	LABORATORY	181,561	121,465	0	151,108	0	60.00
65.00	06500	RESPIRATORY THERAPY	52,924	22,795	0	92,474	0	65.00
66.00	06600	PHYSICAL THERAPY	192,276	27,448	23,019	28,199	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	70,865	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	76,989	70,525	0	12,685	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,389	0	0	0	0	90.00
90.01	09001	WOUND CENTER	55,011	15,345	0	5,172	0	90.01
91.00	09100	EMERGENCY	28,778	71,627	0	55,059	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	313,604	57,563	0	323,200	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,754,406	1,847,365	291,836	2,500,145	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,930	2,017	619	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	338,802	5,869	0	1,762	0	192.00
192.01	19201	NONREIMBURSABLE	0	0	4,896	9,671	0	192.01
194.00	07950	CROSSTOWN SQUARE	4,975	0	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,098,183	1,866,164	298,749	2,512,197	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			2A	4.00	5.00	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,540	4,540				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	975,478	137	975,615			5.00
7.00	00700	OPERATION OF PLANT	350,032	82	49,450	399,564		7.00
7.01	00701	OPERATION OF PLANT IRC	12,783	0	211	0	12,994	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	20,439	5	681	6,204	47	8.00
9.00	00900	HOUSEKEEPING	18,863	0	11,660	2,830	103	9.00
10.00	01000	DIETARY	68,633	0	9,909	13,687	0	10.00
11.00	01100	CAFETERIA	23,768	0	392	7,599	0	11.00
13.00	01300	NURSING ADMINISTRATION	15,468	104	12,625	2,022	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	143,460	17	12,521	17,333	0	14.00
15.00	01500	PHARMACY	224,109	260	34,814	12,025	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,309	0	18,213	7,132	0	16.00
17.00	01700	SOCIAL SERVICE	8,949	0	148	2,861	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	643,031	908	129,161	111,479	0	30.00
31.00	03100	INTENSIVE CARE UNIT	87,144	139	19,441	9,693	0	31.00
43.00	04300	NURSERY	17,583	34	4,732	5,621	0	43.00
44.00	04400	SKILLED NURSING FACILITY	216,136	489	88,230	0	7,750	44.00
45.00	04500	NURSING FACILITY	91,674	52	9,845	0	3,734	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	538,059	254	53,837	41,744	0	50.00
53.00	05300	ANESTHESIOLOGY	70,772	0	1,666	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	349,159	171	29,170	22,957	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,385	10	4,163	0	0	55.00
57.00	05700	CT SCAN	171,692	33	8,004	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,725	16	2,210	472	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	255,480	76	20,141	6,241	0	59.00
60.00	06000	LABORATORY	454,134	333	101,312	38,834	0	60.00
65.00	06500	RESPIRATORY THERAPY	168,193	167	24,642	7,288	0	65.00
66.00	06600	PHYSICAL THERAPY	270,942	326	41,903	8,775	1,046	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	70,865	0	23,629	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	46,501	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	67,092	0	0	73.00
76.00	03020	CARDIAC REHAB	160,199	55	9,322	22,548	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,389	12	1,602	0	0	90.00
90.01	09001	WOUND CENTER	75,528	28	7,266	4,906	0	90.01
91.00	09100	EMERGENCY	155,464	347	51,762	22,900	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	694,367	448	56,913	18,403	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,393,752	4,503	953,168	393,554	12,680	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,566	2	0	4,134	92	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	346,433	5	3,337	1,876	0	192.00
192.01	19201	NONREIMBURSABLE	14,567	1	983	0	222	192.01
194.00	07950	CROSSTOWN SQUARE	4,975	22	14,200	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	7	3,927	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,775,293	4,540	975,615	399,564	12,994	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	27,376					8.00
9.00	00900	HOUSEKEEPING	0	33,456				9.00
10.00	01000	DIETARY	0	1,257	93,486			10.00
11.00	01100	CAFETERIA	0	698	74,618	107,075		11.00
13.00	01300	NURSING ADMINISTRATION	0	186	0	2,266	32,671	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	149	1,592	0	956	0	14.00
15.00	01500	PHARMACY	0	377	0	4,788	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	655	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	263	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,036	10,238	17,150	26,766	18,560	30.00
31.00	03100	INTENSIVE CARE UNIT	774	890	1,718	3,452	2,369	31.00
43.00	04300	NURSERY	305	516	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,390	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	612	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,609	3,834	0	6,716	4,215	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,514	2,108	0	5,039	3	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	238	0	55.00
57.00	05700	CT SCAN	729	0	0	869	1	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	131	43	0	346	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	318	573	0	1,096	422	59.00
60.00	06000	LABORATORY	5	2,106	0	11,346	0	60.00
65.00	06500	RESPIRATORY THERAPY	307	669	0	4,986	3	65.00
66.00	06600	PHYSICAL THERAPY	267	961	0	8,251	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	7	1,406	0	1,474	850	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	383	0	90.00
90.01	09001	WOUND CENTER	0	451	0	858	501	90.01
91.00	09100	EMERGENCY	3,927	2,103	0	8,211	5,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,690	0	17,745	23	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,080	32,616	93,486	105,786	32,671	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	464	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	296	172	0	209	0	192.00
192.01	19201	NONREIMBURSABLE	0	204	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	1,080	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
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)	27,376	33,456	93,486	107,075	32,671	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
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	176,028					14.00
15.00	01500	PHARMACY	1,003	277,376				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	48,309			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	12,221		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,391	0	3,753	7,347	984,820	30.00
31.00	03100	INTENSIVE CARE UNIT	2,065	0	804	268	128,757	31.00
43.00	04300	NURSERY	0	0	190	765	29,746	43.00
44.00	04400	SKILLED NURSING FACILITY	4,874	0	1,765	0	327,634	44.00
45.00	04500	NURSING FACILITY	260	0	223	0	106,400	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,828	0	3,721	3,841	677,658	50.00
53.00	05300	ANESTHESIOLOGY	699	0	661	0	73,798	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790	0	2,452	0	413,363	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	4,718	0	586	0	11,100	55.00
57.00	05700	CT SCAN	1,517	0	3,956	0	186,801	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	71	0	823	0	14,837	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,426	0	2,170	0	288,943	59.00
60.00	06000	LABORATORY	1,466	0	7,759	0	617,295	60.00
65.00	06500	RESPIRATORY THERAPY	2,520	0	3,066	0	211,841	65.00
66.00	06600	PHYSICAL THERAPY	419	0	1,879	0	334,769	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,153	0	1,256	0	133,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	76,643	0	2,304	0	125,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	277,376	4,649	0	349,117	73.00
76.00	03020	CARDIAC REHAB	236	0	204	0	196,301	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27	0	33	0	4,446	90.00
90.01	09001	WOUND CENTER	1,239	0	879	0	91,656	90.01
91.00	09100	EMERGENCY	5,971	0	5,176	0	261,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,702	0	0	0	792,291	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	176,018	277,376	48,309	12,221	6,362,509	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	20,258	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	352,328	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	15,977	192.01
194.00	07950	CROSSTOWN SQUARE	9	0	0	0	20,286	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	3,934	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	1	0	0	0	1	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	176,028	277,376	48,309	12,221	6,775,293	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B Part II | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP RELATED IRC				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT IRC				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	984,820		30.00
31.00	03100	INTENSIVE CARE UNIT	0	128,757		31.00
43.00	04300	NURSERY	0	29,746		43.00
44.00	04400	SKILLED NURSING FACILITY	0	327,634		44.00
45.00	04500	NURSING FACILITY	0	106,400		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	677,658		50.00
53.00	05300	ANESTHESIOLOGY	0	73,798		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	413,363		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,100		55.00
57.00	05700	CT SCAN	0	186,801		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,837		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	288,943		59.00
60.00	06000	LABORATORY	0	617,295		60.00
65.00	06500	RESPIRATORY THERAPY	0	211,841		65.00
66.00	06600	PHYSICAL THERAPY	0	334,769		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	133,903		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	125,448		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	349,117		73.00
76.00	03020	CARDIAC REHAB	0	196,301		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	4,446		90.00
90.01	09001	WOUND CENTER	0	91,656		90.01
91.00	09100	EMERGENCY	0	261,585		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	792,291		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,362,509		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,258		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	352,328		192.00
192.01	19201	NONREIMBURSABLE	0	15,977		192.01
194.00	07950	CROSSTOWN SQUARE	0	20,286		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	3,934		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0		194.03
194.04	07951	OUTREACH	0	1		194.04
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	6,775,293		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	230,211					1.00
1.01	00101	NEW CAP RELATED IRC	0	52,420				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,350,948			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC			0	0		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	560	0	0	0	27,571,161	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,750	0	191,198	0	832,281	5.00
7.00	00700	OPERATION OF PLANT	21,729	0	76,595	0	497,625	7.00
7.01	00701	OPERATION OF PLANT IRC	0	2,243	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,394	181	0	0	30,620	8.00
9.00	00900	HOUSEKEEPING	1,092	396	4,979	0	0	9.00
10.00	01000	DIETARY	5,281	0	7,228	0	0	10.00
11.00	01100	CAFETERIA	2,932	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	780	0	4,873	0	629,421	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	27,733	0	105,205	14.00
15.00	01500	PHARMACY	4,640	0	98,400	0	1,576,330	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,014	0	211,866	0	5,562,965	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	0	42,541	0	844,164	31.00
43.00	04300	NURSERY	2,169	0	0	0	207,907	43.00
44.00	04400	SKILLED NURSING FACILITY	0	29,929	15,066	0	2,962,254	44.00
45.00	04500	NURSING FACILITY	0	14,419	8,888	0	314,727	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,107	0	297,046	0	1,541,593	50.00
53.00	05300	ANESTHESIOLOGY	0	0	58,798	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	242,959	0	1,033,721	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	60,967	55.00
57.00	05700	CT SCAN	0	0	143,173	0	199,820	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	5,942	0	96,620	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	211,040	0	462,421	59.00
60.00	06000	LABORATORY	14,984	0	141,409	0	2,016,249	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	86,538	0	1,011,698	65.00
66.00	06600	PHYSICAL THERAPY	3,386	4,039	26,389	0	1,976,462	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	66,316	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	8,700	0	11,871	0	335,927	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	71,750	90.00
90.01	09001	WOUND CENTER	1,893	0	4,840	0	170,950	90.01
91.00	09100	EMERGENCY	8,836	0	51,525	0	2,102,986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,101	0	302,457	0	2,712,666	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	227,892	51,207	2,339,670	0	27,357,329	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	354	579	0	9,141	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	1,649	0	28,221	192.00
192.01	19201	NONREIMBURSABLE	0	859	9,050	0	4,029	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0	0	131,108	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	41,333	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
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)	1,866,164	298,749	2,512,197	0	2,756,404	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.106320	5.699142	1.068589	0.000000	0.099974	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					4,540	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000165	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT IRC (SQUARE FEET IRC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5A	5.00	7.00	7.01	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-14,566,099	59,174,828				5.00
7.00	00700	OPERATION OF PLANT	0	2,999,355	154,172			7.00
7.01	00701	OPERATION OF PLANT IRC	0	12,783	0	50,177		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	41,276	2,394	181	626,476	8.00
9.00	00900	HOUSEKEEPING	0	707,238	1,092	396	0	9.00
10.00	01000	DIETARY	0	601,033	5,281	0	0	10.00
11.00	01100	CAFETERIA	0	23,768	2,932	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	765,736	780	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	759,425	6,688	0	3,403	14.00
15.00	01500	PHARMACY	0	2,111,581	4,640	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,104,693	2,752	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,949	1,104	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,834,366	43,014	0	138,121	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,179,146	3,740	0	17,705	31.00
43.00	04300	NURSERY	0	287,011	2,169	0	6,988	43.00
44.00	04400	SKILLED NURSING FACILITY	0	5,351,506	0	29,929	192,038	44.00
45.00	04500	NURSING FACILITY	0	597,110	0	14,419	14,014	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,265,398	16,107	0	82,587	50.00
53.00	05300	ANESTHESIOLOGY	0	101,025	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,769,266	8,858	0	34,642	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	252,494	0	0	0	55.00
57.00	05700	CT SCAN	0	485,502	0	0	16,686	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	134,016	182	0	2,996	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,221,610	2,408	0	7,282	59.00
60.00	06000	LABORATORY	0	6,144,984	14,984	0	103	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,494,607	2,812	0	7,022	65.00
66.00	06600	PHYSICAL THERAPY	0	2,541,572	3,386	4,039	6,102	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,433,192	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,820,446	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,069,363	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	565,431	8,700	0	151	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	97,194	0	0	0	90.00
90.01	09001	WOUND CENTER	0	440,682	1,893	0	0	90.01
91.00	09100	EMERGENCY	0	3,139,558	8,836	0	89,861	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,452,002	7,101	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-14,566,099	57,813,318	151,853	48,964	619,701	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,717	0	1,595	354	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	202,432	724	0	6,775	192.00
192.01	19201	NONREIMBURSABLE	0	59,644	0	859	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	861,262	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	238,172	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	5,769	0	0	0	0	194.04
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)		14,566,099	3,737,658	15,930	109,532	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.246154	24.243429	0.317476	0.174838	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		975,615	399,564	12,994	27,376	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.016487	2.591677	0.258963	0.043698	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet B-1 | Date/Time Prepared: 11/21/2016 11:20 am

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT IRC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	140,569					9.00
10.00	01000	DIETARY	5,281	155,206				10.00
11.00	01100	CAFETERIA	2,932	123,880	40,543			11.00
13.00	01300	NURSING ADMINISTRATION	780	0	858	361,523		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,688	0	362	0	6,477,718	14.00
15.00	01500	PHARMACY	1,583	0	1,813	0	36,893	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,104	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,014	28,473	10,135	205,374	382,372	30.00
31.00	03100	INTENSIVE CARE UNIT	3,740	2,853	1,307	26,217	75,999	31.00
43.00	04300	NURSERY	2,169	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	179,380	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	9,576	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,107	0	2,543	46,637	656,051	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	25,738	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,858	0	1,908	32	29,086	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	90	0	173,607	55.00
57.00	05700	CT SCAN	0	0	329	11	55,830	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	131	3	2,613	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,408	0	415	4,670	89,279	59.00
60.00	06000	LABORATORY	8,850	0	4,296	0	53,937	60.00
65.00	06500	RESPIRATORY THERAPY	2,812	0	1,888	33	92,732	65.00
66.00	06600	PHYSICAL THERAPY	4,039	0	3,124	0	15,404	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,404,041	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,820,446	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	5,908	0	558	9,401	8,673	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	145	0	991	90.00
90.01	09001	WOUND CENTER	1,893	0	325	5,545	45,592	90.01
91.00	09100	EMERGENCY	8,836	0	3,109	63,341	219,722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	7,101	0	6,719	259	99,420	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	137,037	155,206	40,055	361,523	6,477,382	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,949	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	724	0	79	0	0	192.00
192.01	19201	NONREIMBURSABLE	859	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	0	409	0	315	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	21	194.04
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)	907,927	911,120	846,863	996,095	1,159,854	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.458942	5.870392	20.888020	2.755274	0.179053	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33,456	93,486	107,075	32,671	176,028	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.238004	0.602335	2.641023	0.090370	0.027174	205.00

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		Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
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	4,069,363				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	206,701,795			16.00
17.00	01700	SOCIAL SERVICE	0	0	7,877		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	16,039,710	4,735		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,434,899	173		31.00
43.00	04300	NURSERY	0	813,292	493		43.00
44.00	04400	SKILLED NURSING FACILITY	0	7,541,648	0		44.00
45.00	04500	NURSING FACILITY	0	955,012	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	15,900,513	2,476		50.00
53.00	05300	ANESTHESIOLOGY	0	2,826,227	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,479,765	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,505,877	0		55.00
57.00	05700	CT SCAN	0	16,905,163	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,519,154	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,273,846	0		59.00
60.00	06000	LABORATORY	0	33,410,691	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	13,101,224	0		65.00
66.00	06600	PHYSICAL THERAPY	0	8,029,689	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,365,576	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,847,223	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,069,363	19,865,893	0		73.00
76.00	03020	CARDIAC REHAB	0	871,973	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	139,638	0		90.00
90.01	09001	WOUND CENTER	0	3,756,447	0		90.01
91.00	09100	EMERGENCY	0	22,118,335	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,069,363	206,701,795	7,877		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	NONREIMBURSABLE	0	0	0		192.01
194.00	07950	CROSSTOWN SQUARE	0	0	0		194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0		194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0		194.03
194.04	07951	OUTREACH	0	0	0		194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,798,546	1,461,111	45,048		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.687711	0.007069	5.718929		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	277,376	48,309	12,221		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.068162	0.000234	1.551479		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,261,221		12,261,221	0	12,261,221	30.00
31.00	03100	INTENSIVE CARE UNIT	1,742,482		1,742,482	0	1,742,482	31.00
43.00	04300	NURSERY	434,043		434,043	0	434,043	43.00
44.00	04400	SKILLED NURSING FACILITY	6,797,309		6,797,309	0	6,797,309	44.00
45.00	04500	NURSING FACILITY	759,585		759,585	0	759,585	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,003,796		5,003,796	0	5,003,796	50.00
53.00	05300	ANESTHESIOLOGY	150,480		150,480	0	150,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,602,027		2,602,027	0	2,602,027	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	365,325		365,325	0	365,325	55.00
57.00	05700	CT SCAN	744,329		744,329	0	744,329	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	201,206		201,206	0	201,206	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,700,597		1,700,597	0	1,700,597	59.00
60.00	06000	LABORATORY	8,413,548		8,413,548	3	8,413,551	60.00
65.00	06500	RESPIRATORY THERAPY	2,098,819	0	2,098,819	18	2,098,837	65.00
66.00	06600	PHYSICAL THERAPY	3,402,489	0	3,402,489	0	3,402,489	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,075,305		2,075,305	0	2,075,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,089,327		4,089,327	0	4,089,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,010,031		8,010,031	0	8,010,031	73.00
76.00	03020	CARDIAC REHAB	998,992		998,992	0	998,992	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	125,312		125,312	0	125,312	90.00
90.01	09001	WOUND CENTER	664,062		664,062	0	664,062	90.01
91.00	09100	EMERGENCY	4,634,530		4,634,530	35	4,634,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,629,014		1,629,014		1,629,014	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,678,606		4,678,606	45	4,678,651	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	73,582,435	0	73,582,435	101	73,582,536	200.00
201.00		Less Observation Beds	1,629,014		1,629,014		1,629,014	201.00
202.00		Total (see instructions)	71,953,421	0	71,953,421	101	71,953,522	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 11:20 am

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	16,039,710		16,039,710			30.00
31.00	03100	INTENSIVE CARE UNIT	3,434,899		3,434,899			31.00
43.00	04300	NURSERY	813,292		813,292			43.00
44.00	04400	SKILLED NURSING FACILITY	7,541,648		7,541,648			44.00
45.00	04500	NURSING FACILITY	955,012		955,012			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,748,548	10,151,965	15,900,513	0.314694	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,058,711	1,767,516	2,826,227	0.053244	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,640,925	8,838,840	10,479,765	0.248291	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	446,385	2,059,492	2,505,877	0.145787	0.000000	55.00
57.00	05700	CT SCAN	3,569,992	13,335,171	16,905,163	0.044030	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	425,967	3,093,187	3,519,154	0.057175	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,323,279	4,950,567	9,273,846	0.183376	0.000000	59.00
60.00	06000	LABORATORY	8,442,344	24,968,346	33,410,690	0.251822	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,494,321	5,606,903	13,101,224	0.160200	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,461,375	3,568,314	8,029,689	0.423739	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,692,837	2,672,739	5,365,576	0.386781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,403,704	3,443,519	9,847,223	0.415277	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,292,663	10,573,230	19,865,893	0.403205	0.000000	73.00
76.00	03020	CARDIAC REHAB	31,801	840,172	871,973	1.145669	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,316	131,322	139,638	0.897406	0.000000	90.00
90.01	09001	WOUND CENTER	19,071	3,737,376	3,756,447	0.176779	0.000000	90.01
91.00	09100	EMERGENCY	4,073,975	18,044,360	22,118,335	0.209533	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	61,398	2,477,211	2,538,609	0.641696	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,721,490	8,721,490	0.536446	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	88,980,173	128,981,720	217,961,893			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	88,980,173	128,981,720	217,961,893			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 11:20 am

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
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.314694		50.00
53.00	05300	ANESTHESIOLOGY	0.053244		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248291		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145787		55.00
57.00	05700	CT SCAN	0.044030		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057175		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.183376		59.00
60.00	06000	LABORATORY	0.251822		60.00
65.00	06500	RESPIRATORY THERAPY	0.160202		65.00
66.00	06600	PHYSICAL THERAPY	0.423739		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386781		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415277		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403205		73.00
76.00	03020	CARDIAC REHAB	1.145669		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.897406		90.00
90.01	09001	WOUND CENTER	0.176779		90.01
91.00	09100	EMERGENCY	0.209535		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.641696		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.536451		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 11:20 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,261,221		12,261,221	0	12,261,221	30.00
31.00	03100	INTENSIVE CARE UNIT	1,742,482		1,742,482	0	1,742,482	31.00
43.00	04300	NURSERY	434,043		434,043	0	434,043	43.00
44.00	04400	SKILLED NURSING FACILITY	6,797,309		6,797,309	0	6,797,309	44.00
45.00	04500	NURSING FACILITY	759,585		759,585	0	759,585	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,003,796		5,003,796	0	5,003,796	50.00
53.00	05300	ANESTHESIOLOGY	150,480		150,480	0	150,480	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,602,027		2,602,027	0	2,602,027	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	365,325		365,325	0	365,325	55.00
57.00	05700	CT SCAN	744,329		744,329	0	744,329	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	201,206		201,206	0	201,206	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,700,597		1,700,597	0	1,700,597	59.00
60.00	06000	LABORATORY	8,413,548		8,413,548	3	8,413,551	60.00
65.00	06500	RESPIRATORY THERAPY	2,098,819	0	2,098,819	18	2,098,837	65.00
66.00	06600	PHYSICAL THERAPY	3,402,489	0	3,402,489	0	3,402,489	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,075,305		2,075,305	0	2,075,305	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,089,327		4,089,327	0	4,089,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,010,031		8,010,031	0	8,010,031	73.00
76.00	03020	CARDIAC REHAB	998,992		998,992	0	998,992	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	125,312		125,312	0	125,312	90.00
90.01	09001	WOUND CENTER	664,062		664,062	0	664,062	90.01
91.00	09100	EMERGENCY	4,634,530		4,634,530	35	4,634,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,629,014		1,629,014		1,629,014	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,678,606		4,678,606	45	4,678,651	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	73,582,435	0	73,582,435	101	73,582,536	200.00
201.00		Less Observation Beds	1,629,014		1,629,014		1,629,014	201.00
202.00		Total (see instructions)	71,953,421	0	71,953,421	101	71,953,522	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 11:20 am

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	16,039,710		16,039,710			30.00
31.00	03100	INTENSIVE CARE UNIT	3,434,899		3,434,899			31.00
43.00	04300	NURSERY	813,292		813,292			43.00
44.00	04400	SKILLED NURSING FACILITY	7,541,648		7,541,648			44.00
45.00	04500	NURSING FACILITY	955,012		955,012			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,748,548	10,151,965	15,900,513	0.314694	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,058,711	1,767,516	2,826,227	0.053244	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,640,925	8,838,840	10,479,765	0.248291	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	446,385	2,059,492	2,505,877	0.145787	0.000000	55.00
57.00	05700	CT SCAN	3,569,992	13,335,171	16,905,163	0.044030	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	425,967	3,093,187	3,519,154	0.057175	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,323,279	4,950,567	9,273,846	0.183376	0.000000	59.00
60.00	06000	LABORATORY	8,442,344	24,968,346	33,410,690	0.251822	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,494,321	5,606,903	13,101,224	0.160200	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,461,375	3,568,314	8,029,689	0.423739	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,692,837	2,672,739	5,365,576	0.386781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,403,704	3,443,519	9,847,223	0.415277	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,292,663	10,573,230	19,865,893	0.403205	0.000000	73.00
76.00	03020	CARDIAC REHAB	31,801	840,172	871,973	1.145669	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,316	131,322	139,638	0.897406	0.000000	90.00
90.01	09001	WOUND CENTER	19,071	3,737,376	3,756,447	0.176779	0.000000	90.01
91.00	09100	EMERGENCY	4,073,975	18,044,360	22,118,335	0.209533	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	61,398	2,477,211	2,538,609	0.641696	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	8,721,490	8,721,490	0.536446	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	88,980,173	128,981,720	217,961,893			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	88,980,173	128,981,720	217,961,893			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet C Part I Date/Time Prepared: 11/21/2016 11:20 am

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
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	CARDIAC REHAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	WOUND CENTER	0.000000		90.01
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
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part I Date/Time Prepared: 11/21/2016 11:20 am

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	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	984,820	0	984,820	13,789	71.42	30.00
31.00	INTENSIVE CARE UNIT	128,757		128,757	1,045	123.21	31.00
43.00	NURSERY	29,746		29,746	736	40.42	43.00
44.00	SKILLED NURSING FACILITY	327,634		327,634	25,638	12.78	44.00
45.00	NURSING FACILITY	106,400		106,400	8,954	11.88	45.00
200.00	Total (lines 30-199)	1,577,357		1,577,357	50,162		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	4,645	331,746		30.00
31.00	INTENSIVE CARE UNIT	425	52,364		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	5,693	72,757		44.00
45.00	NURSING FACILITY	0	0		45.00
200.00	Total (lines 30-199)	10,763	456,867		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part II Date/Time Prepared: 11/21/2016 11:20 am

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	677,658	15,900,513	0.042619	2,398,555	102,224	50.00
53.00	05300	ANESTHESIOLOGY	73,798	2,826,227	0.026112	348,728	9,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	413,363	10,479,765	0.039444	611,831	24,133	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,100	2,505,877	0.004430	253,936	1,125	55.00
57.00	05700	CT SCAN	186,801	16,905,163	0.011050	960,412	10,613	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,837	3,519,154	0.004216	204,425	862	58.00
59.00	05900	CARDIAC CATHETERIZATION	288,943	9,273,846	0.031157	1,851,029	57,673	59.00
60.00	06000	LABORATORY	617,295	33,410,690	0.018476	3,088,059	57,055	60.00
65.00	06500	RESPIRATORY THERAPY	211,841	13,101,224	0.016170	3,764,454	60,871	65.00
66.00	06600	PHYSICAL THERAPY	334,769	8,029,689	0.041691	671,022	27,976	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,903	5,365,576	0.024956	1,299,198	32,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	125,448	9,847,223	0.012739	3,365,390	42,872	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	349,117	19,865,893	0.017574	4,237,663	74,473	73.00
76.00	03020	CARDIAC REHAB	196,301	871,973	0.225123	14,011	3,154	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,446	139,638	0.031839	2,966	94	90.00
90.01	09001	WOUND CENTER	91,656	3,756,447	0.024400	16,290	397	90.01
91.00	09100	EMERGENCY	261,585	22,118,335	0.011827	2,204,520	26,073	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	130,842	2,538,609	0.051541	13,151	678	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	4,123,703	180,455,842		25,305,640	531,802	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part III Date/Time Prepared: 11/21/2016 11:20 am

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
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
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	13,789	0.00	4,645	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,045	0.00	425	0		31.00
43.00	04300	NURSERY	736	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	25,638	0.00	5,693	0		44.00
45.00	04500	NURSING FACILITY	8,954	0.00	0	0		45.00
200.00		Total (lines 30-199)	50,162		10,763	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/21/2016 11:20 am

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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	90.01
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
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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/21/2016 11:20 am

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	15,900,513	0.000000	0.000000	2,398,555	50.00
53.00	05300	ANESTHESIOLOGY	0	2,826,227	0.000000	0.000000	348,728	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,479,765	0.000000	0.000000	611,831	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,505,877	0.000000	0.000000	253,936	55.00
57.00	05700	CT SCAN	0	16,905,163	0.000000	0.000000	960,412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,519,154	0.000000	0.000000	204,425	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,273,846	0.000000	0.000000	1,851,029	59.00
60.00	06000	LABORATORY	0	33,410,690	0.000000	0.000000	3,088,059	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,101,224	0.000000	0.000000	3,764,454	65.00
66.00	06600	PHYSICAL THERAPY	0	8,029,689	0.000000	0.000000	671,022	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,365,576	0.000000	0.000000	1,299,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,847,223	0.000000	0.000000	3,365,390	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,865,893	0.000000	0.000000	4,237,663	73.00
76.00	03020	CARDIAC REHAB	0	871,973	0.000000	0.000000	14,011	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	139,638	0.000000	0.000000	2,966	90.00
90.01	09001	WOUND CENTER	0	3,756,447	0.000000	0.000000	16,290	90.01
91.00	09100	EMERGENCY	0	22,118,335	0.000000	0.000000	2,204,520	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,538,609	0.000000	0.000000	13,151	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	180,455,842			25,305,640	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV Date/Time Prepared: 11/21/2016 11:20 am

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		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	2,509,463	0		50.00
53.00	05300	ANESTHESIOLOGY	0	384,804	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,548,021	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	481,991	0		55.00
57.00	05700	CT SCAN	0	3,498,401	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	608,275	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,830,077	0		59.00
60.00	06000	LABORATORY	0	2,680,608	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,621,767	0		65.00
66.00	06600	PHYSICAL THERAPY	0	19,914	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	651,897	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,071,300	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,849,202	0		73.00
76.00	03020	CARDIAC REHAB	0	363,401	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CENTER	0	1,799,110	0		90.01
91.00	09100	EMERGENCY	0	2,326,709	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	294,985	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	25,539,925	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/21/2016 11:20 am

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	0.314694	2,509,463	0	0	789,713	50.00
53.00	05300	ANESTHESIOLOGY	0.053244	384,804	0	0	20,489	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248291	1,548,021	0	0	384,360	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145787	481,991	0	0	70,268	55.00
57.00	05700	CT SCAN	0.044030	3,498,401	0	0	154,035	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057175	608,275	0	0	34,778	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.183376	1,830,077	0	0	335,592	59.00
60.00	06000	LABORATORY	0.251822	2,680,608	0	400	675,036	60.00
65.00	06500	RESPIRATORY THERAPY	0.160200	1,621,767	0	0	259,807	65.00
66.00	06600	PHYSICAL THERAPY	0.423739	19,914	0	0	8,438	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386781	651,897	0	0	252,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415277	1,071,300	0	0	444,886	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403205	3,849,202	0	15,755	1,552,017	73.00
76.00	03020	CARDIAC REHAB	1.145669	363,401	0	0	416,337	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.897406	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0.176779	1,799,110	0	0	318,045	90.01
91.00	09100	EMERGENCY	0.209533	2,326,709	0	0	487,522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.641696	294,985	0	0	189,291	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.536446		0			95.00
200.00		Subtotal (see instructions)		25,539,925	0	16,155	6,392,755	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		25,539,925	0	16,155	6,392,755	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part V Date/Time Prepared: 11/21/2016 11:20 am

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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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	101		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,352		73.00
76.00	03020	CARDIAC REHAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CENTER	0	0		90.01
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
200.00		Subtotal (see instructions)	0	6,453		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	6,453		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Skilled Nursing Facility | 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	0	90.01
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
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: 140275 | Component CCN: 145703 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Skilled Nursing Facility | 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	15,900,513	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,826,227	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,479,765	0.000000	0.000000	19,584	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,505,877	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	16,905,163	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,519,154	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,273,846	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	33,410,690	0.000000	0.000000	61,140	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,101,224	0.000000	0.000000	76,449	65.00
66.00	06600	PHYSICAL THERAPY	0	8,029,689	0.000000	0.000000	1,925,051	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,365,576	0.000000	0.000000	1,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,847,223	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,865,893	0.000000	0.000000	367,414	73.00
76.00	03020	CARDIAC REHAB	0	871,973	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	139,638	0.000000	0.000000	0	90.00
90.01	09001	WOUND CENTER	0	3,756,447	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	22,118,335	0.000000	0.000000	750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,538,609	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	180,455,842			2,452,133	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D Part IV | Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	CARDIAC REHAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	WOUND CENTER	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 11:20 am

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)	13,789	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,789	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,957	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)	4,645	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)	12,261,221	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)	12,261,221	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)	12,261,221	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)	889.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,130,334	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)	4,130,334	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,742,482	1,045	1,667.45	425	708,666	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)	7,121,451	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	11,960,451	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)	384,110	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	531,802	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	915,912	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	11,044,539	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,832	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	889.20	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,629,014	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 11:20 am

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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	984,820	12,261,221	0.080320	1,629,014	130,842	90.00
91.00	Nursing School cost	0	12,261,221	0.000000	1,629,014	0	91.00
92.00	Allied health cost	0	12,261,221	0.000000	1,629,014	0	92.00
93.00	All other Medical Education	0	12,261,221	0.000000	1,629,014	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/21/2016 11:20 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	25,638	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,638	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)	25,638	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)	5,693	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)	6,797,309	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)	6,797,309	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)	6,797,309	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-1 | Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	6,797,309	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	265.13	71.00
72.00	Program routine service cost (line 9 x line 71)	1,509,385	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,509,385	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,509,385	83.00
84.00	Program inpatient ancillary services (see instructions)	997,200	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,506,585	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 11/21/2016 11:20 am
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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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		5,796,660		30.00
31.00	03100	INTENSIVE CARE UNIT		1,332,534		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314694	2,398,555	754,811	50.00
53.00	05300	ANESTHESIOLOGY	0.053244	348,728	18,568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248291	611,831	151,912	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145787	253,936	37,021	55.00
57.00	05700	CT SCAN	0.044030	960,412	42,287	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057175	204,425	11,688	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.183376	1,851,029	339,434	59.00
60.00	06000	LABORATORY	0.251822	3,088,059	777,641	60.00
65.00	06500	RESPIRATORY THERAPY	0.160202	3,764,454	603,073	65.00
66.00	06600	PHYSICAL THERAPY	0.423739	671,022	284,338	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386781	1,299,198	502,505	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415277	3,365,390	1,397,569	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403205	4,237,663	1,708,647	73.00
76.00	03020	CARDIAC REHAB	1.145669	14,011	16,052	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.897406	2,966	2,662	90.00
90.01	09001	WOUND CENTER	0.176779	16,290	2,880	90.01
91.00	09100	EMERGENCY	0.209535	2,204,520	461,924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.641696	13,151	8,439	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		25,305,640	7,121,451	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)		25,305,640		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140275 | Component CCN: 145703 | Period: From 07/01/2015 To 06/30/2016 | Worksheet D-3 | Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.314694	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.053244	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248291	19,584	4,863	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145787	0	0	55.00
57.00	05700	CT SCAN	0.044030	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.057175	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.183376	0	0	59.00
60.00	06000	LABORATORY	0.251822	61,140	15,396	60.00
65.00	06500	RESPIRATORY THERAPY	0.160200	76,449	12,247	65.00
66.00	06600	PHYSICAL THERAPY	0.423739	1,925,051	815,719	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386781	1,745	675	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.415277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.403205	367,414	148,143	73.00
76.00	03020	CARDIAC REHAB	1.145669	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.897406	0	0	90.00
90.01	09001	WOUND CENTER	0.176779	0	0	90.01
91.00	09100	EMERGENCY	0.209533	750	157	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.641696	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,452,133	997,200	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)		2,452,133		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140275	Period: From 07/01/2015 To 06/30/2016	Worksheet E Part A Date/Time Prepared: 11/21/2016 11:20 am
	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)	2,812,416	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	8,437,248	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)	24,352	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	4,185,863	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	139.99	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)	4.21	30.00
31.00	Percentage of Medicaid patient days (see instructions)	23.00	31.00
32.00	Sum of lines 30 and 31	27.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)	14.46	33.00
34.00	Disproportionate share adjustment (see instructions)	406,676	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Date/Time Prepared: 11/21/2016 11:20 am

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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)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	691,722	585,264	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	174,352	438,149	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	612,501		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)	12,293,193		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)	12,293,193	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	955,740	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)	13,248,933	59.00
60.00	Primary payer payments	14,595	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	13,234,338	61.00
62.00	Deductibles billed to program beneficiaries	1,487,248	62.00
63.00	Coinsurance billed to program beneficiaries	6,979	63.00
64.00	Allowable bad debts (see instructions)	190,608	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	123,895	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	162,517	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	11,864,006	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	RURAL DEMONSTRATION PROJECT	0	70.50
70.88	SCH or MDH volume decrease adjustment	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-26,878	70.93
70.94	HRR adjustment amount (see instructions)	-39,111	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part A Date/Time Prepared: 11/21/2016 11:20 am

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,798,017	71.00
71.01	Sequestration adjustment (see instructions)		235,960	71.01
72.00	Interim payments		11,444,606	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)		117,451	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E Part B Date/Time Prepared: 11/21/2016 11:20 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,453	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	6,392,755	2.00
3.00	PPS payments	6,205,865	3.00
4.00	Outlier payment (see instructions)	28,869	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.274	5.00
6.00	Line 2 times line 5	1,751,615	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)	6,453	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	16,155	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)	16,155	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)	16,155	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	9,702	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)	6,453	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)	6,234,734	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)	1,263,271	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)	4,977,916	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)	4,977,916	30.00
31.00	Primary payer payments	4,964	31.00
32.00	Subtotal (line 30 minus line 31)	4,972,952	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)	216,977	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	141,035	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	130,317	36.00
37.00	Subtotal (see instructions)	5,113,987	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)	5,113,987	40.00
40.01	Sequestration adjustment (see instructions)	102,280	40.01
41.00	Interim payments	4,997,745	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	13,962	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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 11/21/2016 11:20 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,444,606		4,997,745	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)		11,444,606		4,997,745	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		117,451		13,962	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,562,057		5,011,707	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: 140275	Period:	Worksheet E-1
Component CCN: 145703	From 07/01/2015 To 06/30/2016	Part I Date/Time Prepared: 11/21/2016 11:20 am
Title XVIII	Skilled Nursing Facility	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		2,374,031		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)		2,374,031		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)		2,374,031		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: 140275	Period: From 07/01/2015 To 06/30/2016	Worksheet E-1 Part II Date/Time Prepared: 11/21/2016 11:20 am
	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	4,100	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	5,070	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,985	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	13,002	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	217,961,893	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,978,202	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)	356,217	8.00
9.00	Sequestration adjustment amount (see instructions)	7,124	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	349,093	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	349,093	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140275 Component CCN: 145703	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VI Date/Time Prepared: 11/21/2016 11:20 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	2,724,244	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,724,244	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	301,763	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	2,422,481	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	2,422,481	15.00
15.01	Sequestration adjustment (see instructions)	48,450	15.01
16.00	Interim payments	2,374,031	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G | Date/Time Prepared: 11/21/2016 11:20 am

		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	26,507,405	0	0	0	1.00
2.00	Temporary investments	664,782	0	0	0	2.00
3.00	Notes receivable	1,731,041	0	0	0	3.00
4.00	Accounts receivable	30,593,246	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-17,592,717	0	0	0	6.00
7.00	Inventory	2,417,233	0	0	0	7.00
8.00	Prepaid expenses	495,347	0	0	0	8.00
9.00	Other current assets	2,689,928	0	0	0	9.00
10.00	Due from other funds	875,282	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	48,381,547	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,374,122	0	0	0	12.00
13.00	Land improvements	5,010,215	0	0	0	13.00
14.00	Accumulated depreciation	-1,884,092	0	0	0	14.00
15.00	Buildings	64,288,537	0	0	0	15.00
16.00	Accumulated depreciation	-38,238,297	0	0	0	16.00
17.00	Leasehold improvements	2,090,594	0	0	0	17.00
18.00	Accumulated depreciation	-220,162	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	48,456,255	0	0	0	23.00
24.00	Accumulated depreciation	-40,279,901	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	41,597,271	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	10,761,294	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,761,294	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	100,740,112	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,042,182	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,683,595	0	0	0	38.00
39.00	Payroll taxes payable	996,070	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,698,062	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	3,122,396	0	0	0	43.00
44.00	Other current liabilities	5,882,669	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,424,974	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	7,067,917	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,067,917	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,492,891	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	76,247,221				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)	76,247,221	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	100,740,112	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-1 | Date/Time Prepared: 11/21/2016 11:20 am

		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		70,725,645		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,252,513				2.00
3.00	Total (sum of line 1 and line 2)		75,978,158		0		3.00
4.00	ADDITIONS	269,063		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)		269,063		0		10.00
11.00	Subtotal (line 3 plus line 10)		76,247,221		0		11.00
12.00	DEDUCTIONS	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)		76,247,221		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	ADDITIONS		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	DEDUCTIONS		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: 140275 | Period: From 07/01/2015 To 06/30/2016 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/21/2016 11:20 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	19,502,125		19,502,125	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	7,541,648		7,541,648	7.00
8.00	NURSING FACILITY	955,012		955,012	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	27,998,785		27,998,785	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,551,019		3,551,019	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)	3,551,019		3,551,019	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	31,549,804		31,549,804	17.00
18.00	Ancillary services	62,532,052	136,947,237	199,479,289	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	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	CROSSTOWN SQUARE	1,108,582	0	1,108,582	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	95,190,438	136,947,237	232,137,675	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		88,734,920		29.00
30.00	INCOME TAX	13,314			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)		13,314		36.00
37.00	INCOME TAX	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)		88,748,234		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140275	Period: From 07/01/2015 To 06/30/2016	Worksheet G-3 Date/Time Prepared: 11/21/2016 11:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	232,137,675	1.00
2.00	Less contractual allowances and discounts on patients' accounts	142,084,409	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,053,266	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	88,748,234	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,305,032	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 OPERATING REVENUE	3,574,957	24.00
24.01	NONOPERATING GAINS & LOSSES	438,358	24.01
24.02	ROUNDING	2	24.02
25.00	Total other income (sum of lines 6-24)	4,013,317	25.00
26.00	Total (line 5 plus line 25)	5,318,349	26.00
27.00	COGS	65,836	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	65,836	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,252,513	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140275	Period: From 07/01/2015 To 06/30/2016	Worksheet L Parts I-III Date/Time Prepared: 11/21/2016 11:20 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	899,705	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	5,112	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)	35.87	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)	4.21	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	23.00	8.00
9.00	Sum of lines 7 and 8	27.21	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.66	10.00
11.00	Disproportionate share adjustment (see instructions)	50,923	11.00
12.00	Total prospective capital payments (see instructions)	955,740	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