

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: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet S Parts I-III Date/Time Prepared: 9/26/2016 8:52 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 9/26/2016 Time: 8:52 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by STREAMWOOD ( 144034 ) 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 XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	0	0	0	1,169,498	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	0	0	0	1,169,498	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: 144034		Period: From 07/01/2015 To 06/30/2016		Worksheet S-2 Part I Date/Time Prepared: 9/26/2016 8:51 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1400 EAST IRVING PARK	PO Box:							1.00	
2.00	City: STREAMWOOD	State: IL		Zip Code: 60107		County: COOK			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		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	STREAMWOOD	144034	16974	4	05/01/1991	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2015	06/30/2016		20.00	
21.00	Type of Control (see instructions)					4			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/26/2016 8:51 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	XVII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0
<b>Inpatient Rehabilitation Facility PPS</b>						
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
				1.00	2.00	3.00
<b>Long Term Care Hospital PPS</b>						
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
<b>TEFRA Providers</b>						
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	
<b>Title V and XIX Services</b>						
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	Y	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 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	0.00	97.00	
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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		
<b>Miscellaneous Cost Reporting Information</b>						
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.	0			118.00	
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01	
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00	
<b>Transplant Center Information</b>						
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: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/26/2016 8:51 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		399001		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: UNIVERSAL HEALTH SERVICES	Contractor's Name: 399001		Contractor's Number: 399001		141.00
142.00	Street: 367 SOUTH GULPH ROAD	PO Box:				142.00
143.00	City: KING OF PRUSSIA	State: PA		Zip Code: 19406		143.00
						1.00
144.00	Are provider based physicians' costs included in Worksheet A?		Y			144.00
				1.00 2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00
		Part A		Part B		Title V
		1.00		2.00		3.00
						Title XIX
						4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N			165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		N			167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0			168.00
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)		0.00			169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part I Date/Time Prepared: 9/26/2016 8:51 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)				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: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/26/2016 8:51 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.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/22/2016	Y	08/22/2016
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/26/2016 8:51 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		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		Y	12/31/2011	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
<b>Cost Report Preparer Contact Information</b>					
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.	KEVIN		SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	UHS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-312-5742		KEVIN.SMI TH@UHSINC.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet S-2 Part II Date/Time Prepared: 9/26/2016 8:51 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	178	65,148	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		178	65,148	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		178	65,148	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			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)		178				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: 144034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 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)	150	17,191	38,077			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	150	17,191	38,077			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)	150	17,191	38,077	0.00	257.30	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE			0	0.00	0.00	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	257.30	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144034

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	14	1,302	3,330	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	14	1,302	3,330	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				0	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 UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet S-10 Date/Time Prepared: 9/26/2016 8:51 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.345148	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			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		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	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
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>				
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
<b>Other state or local government indigent care program (see instructions for each line)</b>				
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
<b>Uncompensated care (see instructions for each line)</b>				
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
			1.00	
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			0
27.00	Medicare bad debts for the entire hospital complex (see instructions)			0
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			0
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			0
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			0
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			0

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144034

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

Worksheet A

Date/Time Prepared:  
9/26/2016 8:51 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		2,284,333	2,284,333	23,012	2,307,345	1.00
2.00	00200		298,168	298,168	113,761	411,929	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	353,812	2,845,602	3,199,414	0	3,199,414	4.00
5.00	00500	2,388,006	4,055,438	6,443,444	-639,557	5,803,887	5.00
7.00	00700	1,336	1,038,880	1,040,216	-4,996	1,035,220	7.00
8.00	00800	0	293,230	293,230	0	293,230	8.00
9.00	00900	0	576,627	576,627	0	576,627	9.00
10.00	01000	288,811	461,758	750,569	0	750,569	10.00
13.00	01300	954,621	1,610	956,231	0	956,231	13.00
16.00	01600	231,892	178,552	410,444	0	410,444	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	7,222,222	2,997,007	10,219,229	0	10,219,229	30.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	84,080	84,080	0	84,080	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	629,366	629,366	0	629,366	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	1,871,161	665,220	2,536,381	157,503	2,693,884	90.00
91.00	09100	0	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		13,311,861	16,409,871	29,721,732	-350,277	29,371,455	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1,594,743	104,192	1,698,935	0	1,698,935	194.01
194.02	07952	0	0	0	350,277	350,277	194.02
194.03	07953	0	0	0	0	0	194.03
200.00		14,906,604	16,514,063	31,420,667	0	31,420,667	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144034

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

Worksheet A  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	18,218	2,325,563	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-51,247	360,682	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	164,432	3,363,846	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,752,518	4,051,369	5.00
7.00	00700	OPERATION OF PLANT	0	1,035,220	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	293,230	8.00
9.00	00900	HOUSEKEEPING	0	576,627	9.00
10.00	01000	DIETARY	-9,227	741,342	10.00
13.00	01300	NURSING ADMINISTRATION	0	956,231	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	410,444	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-2,441,466	7,777,763	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	84,080	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	629,366	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-627,104	2,066,780	90.00
91.00	09100	EMERGENCY	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,698,912	24,672,543	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	EDUCATION	0	1,698,935	194.01
194.02	07952	MARKETING	0	350,277	194.02
194.03	07953	PHP MEALS	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-4,698,912	26,721,755	200.00

RECLASSIFICATIONS

Provider CCN: 144034

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

Worksheet A-6

Date/Time Prepared:  
9/26/2016 8:51 am

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>B - RENT LEASE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	23,012	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	113,761	2.00
3.00		0.00	0	0	3.00
	<b>TOTALS</b>		<b>0</b>	<b>136,773</b>	
<b>C - COMMUNITY RELATIONS</b>					
1.00	MARKETING	194.02	294,670	55,607	1.00
	<b>TOTALS</b>		<b>294,670</b>	<b>55,607</b>	
<b>D - TRANSPORTATION</b>					
1.00	CLINIC	90.00	35,715	124,502	1.00
	<b>TOTALS</b>		<b>35,715</b>	<b>124,502</b>	
500.00	<b>Grand Total: Increases</b>		<b>330,385</b>	<b>316,882</b>	<b>500.00</b>

Provider CCN: 144034

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

Worksheet A-6  
Date/Time Prepared:  
9/26/2016 8:51 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>B - RENT LEASE</b>							
1.00	CLINIC	90.00	0	2,714	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	129,063	10		2.00
3.00	OPERATION OF PLANT	7.00	0	4,996	10		3.00
	TOTALS		0	136,773			
<b>C - COMMUNITY RELATIONS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	294,670	55,607	0		1.00
	TOTALS		294,670	55,607			
<b>D - TRANSPORTATION</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	35,715	124,502	0		1.00
	TOTALS		35,715	124,502			
500.00	Grand Total: Decreases		330,385	316,882			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,240,512	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,349,308	0	0	0	0	3.00
4.00	Building Improvements	412,122	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	2,006,845	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,008,787	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,008,787	0	0	0	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,240,512	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	19,349,308	0				3.00
4.00	Building Improvements	412,122	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	2,006,845	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	24,008,787	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	24,008,787	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
9/26/2016 8:51 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	CAP REL COSTS-BLDG & FIXT	1,096,489	0	0	54,188	1,133,656	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	280,943	0	0	17,225	0	2.00
3.00	Total (sum of lines 1-2)	1,377,432	0	0	71,413	1,133,656	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,284,333				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	298,168				2.00
3.00	Total (sum of lines 1-2)	0	2,582,501				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,114,707	23,012	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	229,696	113,761	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,344,403	136,773	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	54,188	1,133,656	0	2,325,563	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,225	0	0	360,682	2.00
3.00	Total (sum of lines 1-2)	0	71,413	1,133,656	0	2,686,245	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144034

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

Worksheet A-8

Date/Time Prepared:  
9/26/2016 8:51 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.		
			3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	A	-58,121		ADMINISTRATIVE & GENERAL	5.00		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	-3,045,018					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	319,900					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	A	-9,227		DIETARY	10.00		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	*** Cost Center Deleted ***	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	B	18,218		CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	B	-51,247		CAP REL COSTS-MVBLE EQUIP	2.00		9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 PHYSICIAN RECRUITING	B	-9,000		ADMINISTRATIVE & GENERAL	5.00		0	33.00
34.00 PHYSICIAN COSTS	B	-23,259		ADULTS & PEDIATRICS	30.00		0	34.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144034

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

Worksheet A-8

Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
35.00 LEGAL FEES	B	-254,283	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 MISC REVENUE	A	-37,104	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00 PT TRANSPORTATION	B	-9,949	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 PT TRANSPORTATION	B	-293	ADULTS & PEDIATRICS	30.00	0	38.00
39.00 MARKETING	B	-63,801	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00		0		0.00	0	40.00
41.00 REBATES OFFSET FOR INFO ONLY	A	58,121	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00		0		0.00	0	42.00
43.00		0		0.00	0	43.00
44.00 DONATIONS	B	-10,813	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 PHYSICIAN BILLING	B	-100,715	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00		0		0.00	0	46.00
47.00 LOBBYING	B	-7,792	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00 BAD DEBT	B	-1,414,529	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00		0		0.00	0	49.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,698,912				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: 144034

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

Worksheet A-8-1

Date/Time Prepared: 9/26/2016 8:51 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	MANAGEMENT FEE	1,307,055	1,254,600 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	0	-226,103 2.00
3.00	4.00	EMPLOYEE BENEFITS	WORKERS COMP INSURANCE	259,095	94,663 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	112,445	235,535 4.00
5.00	0		0	1,678,595	1,358,695 5.00

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

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

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

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

6.00	B	0.00	UNIVERSAL HEALT	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: 144034

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

Worksheet A-8-1

Date/Time Prepared:  
9/26/2016 8:51 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	52,455	0		1.00
2.00	226,103	0		2.00
3.00	164,432	0		3.00
4.00	-123,090	0		4.00
5.00	319,900			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

6.00	HOSPITAL		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: 144034

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

Worksheet A-8-2

Date/Time Prepared:  
9/26/2016 8:51 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	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,417,914	2,417,914	0	0	0	1.00
2.00	90.00	AGGREGATE-CLINIC	627,104	627,104	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,045,018	3,045,018	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,417,914		1.00
2.00	90.00	AGGREGATE-CLINIC	0	0	0	627,104		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,045,018		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,325,563	2,325,563			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	360,682		360,682		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,363,846	0	0	3,363,846	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,051,369	402,179	62,376	475,615	5.00
7.00 00700	OPERATION OF PLANT	1,035,220	142,379	22,082	309	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	293,230	29,313	4,546	0	8.00
9.00 00900	HOUSEKEEPING	576,627	13,998	2,171	0	9.00
10.00 01000	DIETARY	741,342	116,359	18,047	66,758	10.00
13.00 01300	NURSING ADMINISTRATION	956,231	16,972	2,632	220,659	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	410,444	16,292	2,527	53,601	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	7,777,763	1,118,344	173,448	1,669,399	30.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	84,080	5,608	870	0	60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	629,366	12,617	1,957	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	2,066,780	181,102	28,088	440,771	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	24,672,543	2,055,163	318,744	2,927,112	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	EDUCATION	1,698,935	269,274	41,763	368,622	194.01
194.02 07952	MARKETING	350,277	1,126	175	68,112	194.02
194.03 07953	PHP MEALS	0	0	0	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	26,721,755	2,325,563	360,682	3,363,846	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,991,539				5.00
7.00	00700	OPERATION OF PLANT	275,644	1,475,634			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	75,134	24,287	426,510		8.00
9.00	00900	HOUSEKEEPING	136,168	11,598	0	740,562	9.00
10.00	01000	DIETARY	216,498	96,408	0	49,589	1,305,001
13.00	01300	NURSING ADMINISTRATION	274,841	14,062	0	7,233	0
16.00	01600	MEDICAL RECORDS & LIBRARY	110,916	13,499	0	6,943	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,466,791	926,593	426,510	476,611	1,201,347
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	20,802	4,646	0	2,390	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	147,916	10,454	0	5,377	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	624,049	150,050	0	77,181	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,348,759	1,251,597	426,510	625,324	1,201,347
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	EDUCATION	546,375	223,104	0	114,758	0
194.02	07952	MARKETING	96,405	933	0	480	0
194.03	07953	PHP MEALS	0	0	0	0	103,654
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,991,539	1,475,634	426,510	740,562	1,305,001

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	1,492,630					13.00
16.00	01600	0	614,222				16.00
17.00	01700	0	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,492,630	614,222	0	18,343,658	0	30.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	118,396	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	807,687	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	3,568,021	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		1,492,630	614,222	0	22,837,762	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	3,262,831	0	194.01
194.02	07952	0	0	0	517,508	0	194.02
194.03	07953	0	0	0	103,654	0	194.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,492,630	614,222	0	26,721,755	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

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

Worksheet B  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	MARKETING	194.02
194.03	07953	PHP MEALS	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	32,360	402,179	62,376	496,915	5.00
7.00 00700	OPERATION OF PLANT	0	142,379	22,082	164,461	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	29,313	4,546	33,859	8.00
9.00 00900	HOUSEKEEPING	0	13,998	2,171	16,169	9.00
10.00 01000	DIETARY	0	116,359	18,047	134,406	10.00
13.00 01300	NURSING ADMINISTRATION	0	16,972	2,632	19,604	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	16,292	2,527	18,819	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,118,344	173,448	1,291,792	30.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	5,608	870	6,478	60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	12,617	1,957	14,574	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	181,102	28,088	209,190	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	32,360	2,055,163	318,744	2,406,267	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	EDUCATION	0	269,274	41,763	311,037	194.01
194.02 07952	MARKETING	0	1,126	175	1,301	194.02
194.03 07953	PHP MEALS	0	0	0	0	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	32,360	2,325,563	360,682	2,718,605	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	496,915					5.00
7.00	00700	27,440	191,901				7.00
8.00	00800	7,480	3,158	44,497			8.00
9.00	00900	13,555	1,508	0	31,232		9.00
10.00	01000	21,552	12,538	0	2,091	170,587	10.00
13.00	01300	27,360	1,829	0	305	0	13.00
16.00	01600	11,042	1,755	0	293	0	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	245,578	120,502	44,497	20,100	157,038	30.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	2,071	604	0	101	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	14,725	1,359	0	227	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	62,124	19,513	0	3,255	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		432,927	162,766	44,497	26,372	157,038	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	54,391	29,014	0	4,840	0	194.01
194.02	07952	9,597	121	0	20	0	194.02
194.03	07953	0	0	0	0	13,549	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		496,915	191,901	44,497	31,232	170,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	49,098					13.00
16.00	01600	0	31,909				16.00
17.00	01700	0	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	49,098	31,909	0	1,960,514	0	30.00
46.00	04600	0	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	0	9,254	0	60.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	0	0	30,885	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	294,082	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		49,098	31,909	0	2,294,735	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	399,282	0	194.01
194.02	07952	0	0	0	11,039	0	194.02
194.03	07953	0	0	0	13,549	0	194.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		49,098	31,909	0	2,718,605	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

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

Worksheet B  
Part II  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	EDUCATION	194.01
194.02	07952	MARKETING	194.02
194.03	07953	PHP MEALS	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	109,484				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		109,484			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	14,552,792		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	18,934	18,934	2,057,621	-4,991,539	5.00
7.00 00700	OPERATION OF PLANT	6,703	6,703	1,336	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,380	1,380	0	0	8.00
9.00 00900	HOUSEKEEPING	659	659	0	0	9.00
10.00 01000	DIETARY	5,478	5,478	288,811	0	10.00
13.00 01300	NURSING ADMINISTRATION	799	799	954,621	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	767	767	231,892	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	52,650	52,650	7,222,222	0	30.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	264	264	0	0	60.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	594	594	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	8,526	8,526	1,906,876	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	96,754	96,754	12,663,379	-4,991,539	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	EDUCATION	12,677	12,677	1,594,743	0	194.01
194.02 07952	MARKETING	53	53	294,670	0	194.02
194.03 07953	PHP MEALS	0	0	0	0	194.03
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)	2,325,563	360,682	3,363,846	4,991,539	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21.241122	3.294381	0.231148	0.229705	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	496,915	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.022867	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)	
		7.00	8.00	9.00	10.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	83,847				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,380	38,077			8.00
9.00	00900	HOUSEKEEPING	659	0	81,808		9.00
10.00	01000	DIETARY	5,478	0	5,478	124,087	10.00
13.00	01300	NURSING ADMINISTRATION	799	0	799	0	38,077
16.00	01600	MEDICAL RECORDS & LIBRARY	767	0	767	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	52,650	38,077	52,650	114,231	38,077
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	264	0	264	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	594	0	594	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	8,526	0	8,526	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,117	38,077	69,078	114,231	38,077
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	EDUCATION	12,677	0	12,677	0	0
194.02	07952	MARKETING	53	0	53	0	0
194.03	07953	PHP MEALS	0	0	0	9,856	0
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)	1,475,634	426,510	740,562	1,305,001	1,492,630
203.00		Unit cost multiplier (Wkst. B, Part I)	17.599127	11.201250	9.052440	10.516823	39.200305
204.00		Cost to be allocated (per Wkst. B, Part II)	191,901	44,497	31,232	170,587	49,098
205.00		Unit cost multiplier (Wkst. B, Part II)	2.288704	1.168606	0.381772	1.374737	1.289440

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

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

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	
		16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,077	16.00
17.00	01700	SOCIAL SERVICE	0 38,077	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	38,077	30.00
46.00	04600	OTHER LONG TERM CARE	0 0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 0	54.00
60.00	06000	LABORATORY	0 0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0 0	67.00
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0 0	90.00
91.00	09100	EMERGENCY	0 0	91.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,077 38,077	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0 0	194.00
194.01	07951	EDUCATION	0 0	194.01
194.02	07952	MARKETING	0 0	194.02
194.03	07953	PHP MEALS	0 0	194.03
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)	614,222 0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.131050 0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,909 0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.838012 0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	18,343,658		18,343,658	0	18,343,658	30.00
46.00	04600 OTHER LONG TERM CARE	0		0	0	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	06000 LABORATORY	118,396		118,396	0	118,396	60.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	807,687		807,687	0	807,687	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	3,568,021		3,568,021	0	3,568,021	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
200.00	Subtotal (see instructions)	22,837,762	0	22,837,762	0	22,837,762	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	22,837,762	0	22,837,762	0	22,837,762	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,235,556		54,235,556			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000	LABORATORY	693,230	8	693,238	0.170787	0.000000	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,085,264	0	2,085,264	0.387331	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	9,154,020	9,154,020	0.389776	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
200.00		Subtotal (see instructions)	57,014,050	9,154,028	66,168,078			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	57,014,050	9,154,028	66,168,078			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
46.00	04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.170787			60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.387331			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.389776			90.00
91.00	09100 EMERGENCY	0.000000			91.00
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: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	18,343,658		18,343,658	0	18,343,658 30.00	
46.00	04600 OTHER LONG TERM CARE	0		0	0	0 46.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0		0	0	0 54.00	
60.00	06000 LABORATORY	118,396		118,396	0	118,396 60.00	
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00	
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	807,687		807,687	0	807,687 73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	3,568,021		3,568,021	0	3,568,021 90.00	
91.00	09100 EMERGENCY	0		0	0	0 91.00	
200.00	Subtotal (see instructions)	22,837,762	0	22,837,762	0	22,837,762 200.00	
201.00	Less Observation Beds	0		0	0	0 201.00	
202.00	Total (see instructions)	22,837,762	0	22,837,762	0	22,837,762 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	54,235,556		54,235,556			30.00
46.00	04600 OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	06000 LABORATORY	693,230	8	693,238	0.170787	0.000000	60.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,085,264	0	2,085,264	0.387331	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	9,154,020	9,154,020	0.389776	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	0.000000	0.000000	91.00
200.00	Subtotal (see instructions)	57,014,050	9,154,028	66,168,078			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	57,014,050	9,154,028	66,168,078			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

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

Worksheet C  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
46.00	04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
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: 144034		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part I Date/Time Prepared: 9/26/2016 8:51 am	
		Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,960,514	0	1,960,514	38,077	51.49	30.00
200.00	Total (Lines 30-199)	1,960,514		1,960,514	38,077		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	150	7,724				
200.00	Total (Lines 30-199)	150	7,724				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet D Part II Date/Time Prepared: 9/26/2016 8:51 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0 54.00
60.00	06000	LABORATORY	9,254	693,238	0.013349	1,743	23 60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0 67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,885	2,085,264	0.014811	15,727	233 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	294,082	9,154,020	0.032126	0	0 90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0 91.00
200.00		Total (lines 50-199)	334,221	11,932,522		17,470	256 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144034		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part III Date/Time Prepared: 9/26/2016 8:51 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	PPS	
			1.00	2.00	3.00	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,077	0.00	150	0		30.00
200.00		Total (lines 30-199)	38,077		150	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
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Cost Center Description			Title XVIII				Hospital		PPS
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
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: 144034

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

Worksheet D  
Part IV  
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	54.00
60.00	06000	LABORATORY	0	693,238	0.000000	1,743	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,085,264	0.000000	15,727	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	9,154,020	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	91.00
200.00		Total (lines 50-199)	0	11,932,522		17,470	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
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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		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144034		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part I Date/Time Prepared: 9/26/2016 8:51 am	
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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,960,514	0	1,960,514	38,077	51.49	30.00
200.00	Total (Lines 30-199)	1,960,514		1,960,514	38,077		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	17,191	885,165				
200.00	Total (Lines 30-199)	17,191	885,165				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144034

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

Worksheet D  
Part II  
Date/Time Prepared:  
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Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	06000	LABORATORY	9,254	693,238	0.013349	335,795	4,483	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,885	2,085,264	0.014811	1,010,098	14,961	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	294,082	9,154,020	0.032126	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
200.00		Total (lines 50-199)	334,221	11,932,522		1,345,893	19,444	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144034		Period: From 07/01/2015 To 06/30/2016		Worksheet D Part III Date/Time Prepared: 9/26/2016 8:51 am	
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	
200.00		Total (lines 30-199)	0	0	0	0	0	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,077	0.00	17,191	0	30.00	
200.00		Total (lines 30-199)	38,077		17,191	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description			Title XIX				Hospital		Cost	
			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										
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	0	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00	
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
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Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
			6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	693,238	0.000000	0.000000	335,795	60.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,085,264	0.000000	0.000000	1,010,098	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	9,154,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
200.00		Total (lines 50-199)	0	11,932,522			1,345,893	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

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

Worksheet D  
Part IV  
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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)	Hospital	Cost
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 9/26/2016 8:51 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,077	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,077	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)		38,077	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)		150	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
<b>SWING BED ADJUSTMENT</b>				
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)		18,343,658	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)		18,343,658	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		18,343,658	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		481.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		72,263	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)		72,263	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 9/26/2016 8:51 am
Cost Center Description			Title XVIII	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				6,390 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				78,653 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)				7,724 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				256 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				7,980 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				70,673 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144034		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 9/26/2016 8:51 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,960,514	18,343,658	0.106877	0	0	90.00
91.00	Nursing School cost	0	18,343,658	0.000000	0	0	91.00
92.00	Allied health cost	0	18,343,658	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,343,658	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 9/26/2016 8:51 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,077	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,077	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)		38,077	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)		17,191	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
<b>SWING BED ADJUSTMENT</b>				
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)		18,343,658	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)		18,343,658	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		18,343,658	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		481.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,281,764	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)		8,281,764	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet D-1 Date/Time Prepared: 9/26/2016 8:51 am
Cost Center Description			Title XIX	Hospital	Cost
	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)				448,591
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				8,730,355
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0
52.00	Total Program excludable cost (sum of lines 50 and 51)				0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
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
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144034		Period: From 07/01/2015 To 06/30/2016		Worksheet D-1 Date/Time Prepared: 9/26/2016 8:51 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,960,514	18,343,658	0.106877	0	0	90.00
91.00	Nursing School cost	0	18,343,658	0.000000	0	0	91.00
92.00	Allied health cost	0	18,343,658	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,343,658	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 9/26/2016 8:51 am	
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		213,750		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.170787	1,743	298	60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.387331	15,727	6,092	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.389776	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
200.00	Total (sum of lines 50-94 and 96-98)		17,470	6,390	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)		17,470		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet D-3 Date/Time Prepared: 9/26/2016 8:51 am	
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		26,271,603		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.170787	335,795	57,349	60.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.387331	1,010,098	391,242	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.389776	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
200.00	Total (sum of lines 50-94 and 96-98)		1,345,893	448,591	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,345,893		202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 144034

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
9/26/2016 8:51 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		99,477		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)		99,477		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)		99,477		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		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part II Date/Time Prepared: 9/26/2016 8:51 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		121,471	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		104.035519	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$ .		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		121,471	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		121,471	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		121,471	18.00
19.00	Deductibles		9,016	19.00
20.00	Subtotal (line 18 minus line 19)		112,455	20.00
21.00	Coinsurance		10,948	21.00
22.00	Subtotal (line 20 minus line 21)		101,507	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		101,507	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		101,507	31.00
31.01	Sequestration adjustment (see instructions)		2,030	31.01
32.00	Interim payments		99,477	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144034	Period: From 07/01/2015 To 06/30/2016	Worksheet E-3 Part VII Date/Time Prepared: 9/26/2016 8:51 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		8,730,355		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		8,730,355	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		8,730,355	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		26,271,603		8.00
9.00	Ancillary service charges		1,345,893	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		27,617,496	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		27,617,496	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		18,887,141	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		8,730,355	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		8,730,355	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		8,730,355	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		8,730,355	0	36.00
37.00	ELIMINATE SETTLEMENT		17,837,606	0	37.00
38.00	Subtotal (line 36 ± line 37)		26,567,961	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		26,567,961	0	40.00
41.00	Interim payments		25,398,463	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		1,169,498	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 144034

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

Worksheet G

Date/Time Prepared:  
9/26/2016 8:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-134,983	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,520,635	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	65,040	0	0	0	7.00
8.00	Prepaid expenses	160,276	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,610,968	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,240,512	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	25,932,661	0	0	0	15.00
16.00	Accumulated depreciation	-5,828,554	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,595,979	0	0	0	23.00
24.00	Accumulated depreciation	-1,651,731	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)	23,288,867	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	61,516,900	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	61,516,900	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	93,416,735	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	615,625	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,196,878	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	16,410,016	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,222,519	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,222,519	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	73,194,216				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)	73,194,216	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	93,416,735	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144034

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

Worksheet G-1

Date/Time Prepared:  
9/26/2016 8:51 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		55,923,501		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		17,270,713				2.00
3.00	Total (sum of line 1 and line 2)		73,194,214		0		3.00
4.00		0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		73,194,214		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		73,194,214		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			0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00			0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144034

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
9/26/2016 8:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	54,235,556		54,235,556	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	54,235,556		54,235,556	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	54,235,556		54,235,556	17.00
18.00	Ancillary services	2,778,494	0	2,778,494	18.00
19.00	Outpatient services	0	9,154,020	9,154,020	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	57,014,050	9,154,020	66,168,070	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,420,667		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	PHYSICIAN REVENUE	7,416,135			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)		7,416,135		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,004,532		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144034

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

Worksheet G-3

Date/Time Prepared:  
9/26/2016 8:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,168,070	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,608,537	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,559,533	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,004,532	4.00
5.00	Net income from service to patients (line 3 minus line 4)	14,555,001	5.00
<b>OTHER INCOME</b>			
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	MISC REVENUE	2,715,712	24.00
25.00	Total other income (sum of lines 6-24)	2,715,712	25.00
26.00	Total (line 5 plus line 25)	17,270,713	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	17,270,713	29.00